PRIMARY CARE LOAN (PCL) PROGRAM
POST-GRADUATION CERTIFICATION FORM

As a PCL recipient you are required to practice primary health care for 10 years (including the years spent in residency) or until the loan is repaid in full, whichever occurs first. You are required to submit this Form annually following graduation.

TIME PERIOD: FROM _____ TO _____

Please complete and return this form to us.

NAME: _____

GRADUATION DATE: _____ UNI: _____

HOME ADDRESS: _____

_____

PHONE NUMBERS: WORK _____ HOME _____

CELL_____

WORK ADDRESS: _____

_____

CURRENT STATUS: _____ RESIDENT _____ FELLOW _____ IN PRACTICE

_____ FAMILY MEDICINE _____ GENERAL INTERNAL MEDICINE

_____ GENERAL PEDIATRICS _____ PREVENTIVE MEDICINE

_____ OTHER – PLEASE EXPLAIN BELOW

COMMENTS: _____

_____

_____

_____

I CERTIFY THAT THE INFORMATION CONTAINED ON THIS CERTIFICATION FORM IS ACCURATE AND THAT I AM IN COMPLIANCE WITH THE OBLIGATIONS SPECIFIED IN MY PRIMARY CARE LOAN PROMISSORY NOTE FOR PRIMARY HEALTH CARE SERVICE.

SIGNATURE: _____ DATE: _____

RETURN COMPLETED FORM BY EMAIL TO: cumc-sfp@cumc.columbia.edu

OR BY MAIL TO: Office of Student Financial Aid & Planning, 154 Haven Ave, Suite 405, New York, NY 10032