

SHARP-II Clinician Application
Solicitation 2 closes September 30, 2013

List of information you'll need

- Education information
- Licensure information, if applicable
- Current Employer information, if applicable
- Loan and Lender information, if applying for Loan Repayment
- Past Employer information, if applying for Direct Incentive

Completing this Application

- If you are applying for Loan Repayment, do NOT submit the form before attaching the required Lender Verification forms
- Submit completed application via e-mail to robert.sewell@alaska.gov

Note to Applicants

It is highly recommended that you discuss your participation in SHARP with your employer prior to beginning the application process.

Successful applicants to the SHARP program must be supported by their employers. A Memorandum of Agreement will be executed between the clinician, his/her employer and the State, and will require a match payment by the employer. Practice sites must meet eligibility criteria described on the SHARP website. A particular site/employer may wish to prioritize and/or limit the number of candidates it will support under this program.

Form Sections:

- Part A (1) – Personal Information (All applicants)
- Part A (1) – Education and Professional Information (All applicants)
- Part A (2) – SHARP Support and Service Obligation (All applicants)
- Part A (3) – Practice Site (Already-hired applicants only)
- Part B – Loan Information (Loan Repayment applicants only)
- Part C – Experience (Direct Incentive applicants only)
- Part D – Questions (All applicants)

For any questions about SHARP, and/or about this form, please contact:

Robert Sewell, Ph.D.
SHARP Program Manager
Phone: 907-465-4065 (9:00-5:00 AT)
Email: robert.sewell@alaska.gov (preferred)

Part A (1) – Personal Information (All applicants)

Age and Race information is requested to help Alaska DHSS monitor workforce diversity.

First name		
Middle name		
Last name		
Other names used <i>(list any other names that you have used in your educational or professional life)</i>		
Sex		
Date of birth		
American Citizen	Yes	No
Permanent Resident	Yes	No
Mailing Address		
City		
State		
ZIP		
Country		
Home phone		
Cell phone		
Other contact phone		
Home Email		
Work Email		
Race <i>(check all races with which you identify)</i>	American Indian, Alaska Native, Eskimo or Aleut Asian Native Hawaiian or Other Pacific Islander Black or African American White Some Other Race(s)	
Hispanic Ethnicity	Yes	No
Are you Multi-Racial? <i>For this question, you are multi-racial if you have parents from more than one of the broad race categories listed or if at least one of your parents is multi-racial.</i>	Yes	No
If your answers to this section need further detail, please write your comments here:		

Part A (1) – Education and Professional Information (All applicants)

Professional Designation	Physician Dentist Pharmacist Dental Hygienist Physician Assistant Nurse Practitioner Psychologist Nurse-RN Clinical Social Worker Physical Therapist
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Specialty and/or other credentials	
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Number of years you have worked as a licensed practitioner in THIS occupation	Total Number of Years	
	Year Practice Began	

For each license, indicate the state, license number and date upon which you first practiced with a full, permanent and unencumbered license.

Licensed Occupation	Doctor of Allopathic Medicine (M.D.) Doctor of Osteopathic Medicine (D.O.) Dentist (D.D.S. or D.M.D.) Pharmacist Nurse Practitioner Physician Assistant Dental Hygienist Registered Nurse (RN) Clinical or Counseling Psychologist (Ph.D. or equivalent) Clinical Social Worker Physical Therapist
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State(or Country)	
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License No.	
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Full License Date	
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Do you believe you are exempt from Alaska Licensure?	Yes	No
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List your (a) school, post-graduate or professional program, and (b) residency program (if applicable), and graduation or completion date of the degree required for your employment.

a) School, Program, or Residency Name	
State (or Country):	
Graduation or Completion Date	
b) School, Program, or Residency Name	
State (or Country)	
Graduation or Completion Date	
c) School, Program, or Residency Name	
State (or Country)	
Graduation or Completion Date	

If your answers to this section need further detail, please write your comments here:

Part A (2) – SHARP Support and Service Obligation (All applicants)			
Which type of support are you requesting?	Loan Repayment	Direct Incentive	Both
What level of SHARP support are you requesting (i.e. portion of FTE)?	Full-time	Half-time	
Are you applying to SHARP for a position into which you are already hired?	Yes	No	
<i>If yes:</i>			
Position Title			
Does this position have administrative duties (e.g. management, supervision)?	Yes	No	Don't Know
If "Yes", then what portion of your position involves administrative duties?	%		
Is this job a direct patient care position?	Yes	No	
If "Yes", then what portion of your position involves direct patient care duties?	%		
Is this job a primary care position?	Yes	No	
If "Yes", then what portion of your position involves delivery of primary care?	%		
Do you NOW have, or anticipate having, another service obligation with any other entity?	Yes	No	
<i>Check ANY other service obligation(s) that you have or anticipate having:</i>	National Health Services Corps Loan Repayment National Health Services Corps Scholars Program WWAMI Medical School tuition service obligation USPHS Commissioned Officer Corps Employer-provided sign-on bonus service obligation Employer-provided moving expense service obligation Indian Health Service Loan Repayment Program Nurse Education Loan Repayment Program (aka NURSE Corps LRP) Active Military National Guard Reserve Military Private Foundation Any other service obligation		
<i>If you checked "Private Foundation" or "Any other service obligation," provide specifics:</i>			
When does your Service Obligation end?			
If your answers to this section need further detail, please write your comments here:			

Part A (3) – Practice Site (Already-hired applicants only)

Complete the information requested below for each practice site at which you intend to fulfill your SHARP service obligation. A practice site is a location at which you will provide medical, dental or behavioral health services to residents of a Health Shortage Area. The sponsoring agency is the health care system or organization that owns the practice site. If additional pages are required, attach a copy.

Practice Site 1		
Site Name		
Sponsoring Agency		
Address Line 1		
Address Line 2		
City		
State		
Zip		
Work Phone		
Work Email		
Enter the following information for the Site Representative or Employer Contact if known:		
Name		
Phone		
Email		
The employment date and hours shown below are:	Actual	Expected
Employment date		
Hours per week		
Site Type: Check ALL of the following that describe this Practice Site.	Certified Rural Health Clinic (CRHC) Community Health Center (Sec 300 CHC) or "Look-Alike" Community Mental Health Clinic (CMHC) Critical Access Hospital Private For-Profit Clinic Public Clinic (operated by state or local government) Private Not-for-Profit Clinic Tribal-Managed Health Facility Hospital Hospital-Affiliated Clinic Local Health Department Long-Term Care Facility Prison (Adult Corrections) Prison (Juvenile Justice Detention or Treatment) State Psychiatric Hospital Other	
If you checked "Other," provide specifics:		
If your answers to this section need further detail, please write your comments here:		

Part A (3) – Practice Site (Already-hired applicants only)

Complete the information requested below for each practice site at which you intend to fulfill your SHARP service obligation. A practice site is a location at which you will provide medical, dental or behavioral health services to residents of a Health Shortage Area. The sponsoring agency is the health care system or organization that owns the practice site. If additional pages are required, attach a copy.

Practice Site 2		
Site Name		
Sponsoring Agency		
Address Line 1		
Address Line 2		
City		
State		
Zip		
Work Phone		
Work Email		
Enter the following information for the Site Representative or Employer Contact if known:		
Name		
Phone		
Email		
The employment date and hours shown below are:	Actual	Expected
Employment date		
Hours per week		
Site Type: Check ALL of the following that describe this Practice Site.	Certified Rural Health Clinic (CRHC) Community Health Center (Sec 300 CHC) or "Look-Alike" Community Mental Health Clinic (CMHC) Critical Access Hospital Private For-Profit Clinic Public Clinic (operated by state or local government) Private Not-for-Profit Clinic Tribal-Managed Health Facility Hospital Hospital-Affiliated Clinic Local Health Department Long-Term Care Facility Prison (Adult Corrections) Prison (Juvenile Justice Detention or Treatment) State Psychiatric Hospital Other	
If you checked "Other," provide specifics:		
If your answers to this section need further detail, please write your comments here:		

Part A (3) – Practice Site (Already-hired applicants only)

Complete the information requested below for each practice site at which you intend to fulfill your SHARP service obligation. A practice site is a location at which you will provide medical, dental or behavioral health services to residents of a Health Shortage Area. The sponsoring agency is the health care system or organization that owns the practice site. If additional pages are required, attach a copy.

Practice Site 3		
Site Name		
Sponsoring Agency		
Address Line 1		
Address Line 2		
City		
State		
Zip		
Work Phone		
Work Email		
Enter the following information for the Site Representative or Employer Contact if known:		
Name		
Phone		
Email		
The employment date and hours shown below are:	Actual	Expected
Employment date		
Hours per week		
Site Type: Check ALL of the following that describe this Practice Site.	Certified Rural Health Clinic (CRHC) Community Health Center (Sec 300 CHC) or "Look-Alike" Community Mental Health Clinic (CMHC) Critical Access Hospital Private For-Profit Clinic Public Clinic (operated by state or local government) Private Not-for-Profit Clinic Tribal-Managed Health Facility Hospital Hospital-Affiliated Clinic Local Health Department Long-Term Care Facility Prison (Adult Corrections) Prison (Juvenile Justice Detention or Treatment) State Psychiatric Hospital Other	
If you checked "Other," provide specifics:		
If your answers to this section need further detail, please write your comments here:		

Part B – Loan Information (Loan Repayment applicants only)

- If you are applying for the loan repayment benefit, you must list all educational loans or conditional service agreements for which you have a remaining balance whether or not they entail a service obligation.
- Include only those loans incurred to finance your undergraduate or graduate education and training that led to the professional degree necessary for the position through which you will fulfill your SHARP service obligation.
- If you have consolidated or refinanced any eligible loan with a non-educational loan, no portion of the consolidated/refinanced loan is eligible for loan repayment and must not be listed below or included in your practitioner application lender verifications.
- Please list the information about all of your current education loans/service obligations in the Current Loans section.
- List all original educational loans that have been consolidated into one of your current loans in the Original Loans That Have Been Consolidated section.
- For each education loan that you want considered for SHARP repayment, you must attach a completed *Part B (2) Loan Lender/Holder Information* form. A form is complete when the top portion has been filled out and signed by you, and the bottom portion has been filled out and signed by the lender/holder of the loan(s).
- Steps to complete the *Part B (2) Loan Lender/Holder Information* form:
 1. Complete the top portion of the form. Make sure your name on the form matches your name on the loan documents. If you use a different name here, be sure to enter it in the "Other Names Used" field in Part A (1) - Personal.
 2. Print the form(s), sign and date the printed form(s).
 3. Organizations may list up to four loans in the table provided. If a single holder holds more than four loans, you must send additional copies so that all the loans can be listed in the table provided.
 4. Mail or fax the form(s) to each organization that holds one or more of your loans. You must ask them to complete Section II and then email the form(s) as an attachment back to you.
 5. Repeat for each lending organization that holds one or more of your loans.
 6. Be sure that the information you entered in the Part B (1) - Current Loans section matches the information on the returned form.
 7. Do not submit your application until you have attached all of the necessary completed lender forms.

Part B (1) - Current Loans						<i>(copy additional pages as necessary)</i>			
Account or ID number	Academic period covered by loan (Start – End)	Name of Loan Program	Lender	Balance	Loan entails a service obligation		This a consolidation loan		
					Yes	No	Yes	No	
					Yes	No	Yes	No	
					Yes	No	Yes	No	
					Yes	No	Yes	No	
Original loans that have been consolidated									
For each loan marked as consolidated above, enter each Original Loan Name. If you are unable to provide the original loan names, enter Not Available in the Original Loan Name column.									
Current Loan Account or ID Number			Original Loan Names (separate names with commas)						
If your answers to this section need further detail, please write your comments here:									

Alaska's SHARP Program - Part B (2) Loan Lender/Holder Information Form

On this form, the "lender" refers to the original lender, whereas the "holder" is an entity that has subsequently assumed the promissory note- such as in the case of consolidation of loans. For loans to qualify for repayment, they must have been made to the borrower named in Section I for the purpose of obtaining medical or graduate level education in a health care field or undergraduate coursework leading to their graduate work. All other non-school loans or ineligible school loans must be excluded from reporting on this form.

To the Holder of Notes: The borrower identified in Section I may qualify for loan repayment by the State of Alaska under provisions of Alaska's SHARP program. Complete Section II with the most recent and accurate information regarding the borrower's educational loans (described below). You may list up to four loans in the table included in Section II. If necessary, fill out additional copies of the Part B(2) application.

SECTION I - TO BE COMPLETED BY BORROWER

Last Name		First Name		Middle Name	
Address		City		State	Zip
Home Phone		Fax		Email	
Cell Phone		Academic Period Covered by Loans			
Lender Name			Holder Name		
Lender Address			Holder Address		
City	State	Zip	City	State	Zip
<i>By my signature, I authorize the holder of the promissory note(s) of my student loan/service obligation(s) to release information about my student loan/obligation(s) to the Alaska Department of Health & Social Services for the purposes of qualifying the loan(s) for repayment by the State of Alaska.</i>				Borrower Signature	Date

SECTION II - TO BE COMPLETED BY HOLDER OF NOTES

LENDER/Holder Name			Contact Name				
LENDER/Holder Address			Contact Address				
City	State	Zip	Contact Email				
Account #	Note Date	Name on Loan Program	Lender	Balance	Days Past Due	Remaining Payments (#)	Monthly Payment
Do any of the loans entail a service obligation? Yes No				If yes, which ones:			
LENDER/Holder E.I.N. #:			<i>* Holder of Notes: Email this completed form as an attachment to Borrower</i>				
<i>I certify that the information provided in Section II is true and correct.</i>		Typed or Printed Name of Authorized Official		Signature of Authorized Official		Date	

Part C – Experience (Direct Incentive applicants only)

*Present chronology of directly relevant clinical work experience
Copy page as needed for additional positions*

Position Title #1	
Name of Practice/Agency	
Position Dates	
Position Total Years	
Clinical or Admin. Supervisor	
Supervisor Email	
Supervisor Phone	
Brief Practice Description	
State how this Position/ Background is relevant to you being categorized as "Highly Experienced"	
<p>Site Type</p> <p><i>Check ALL of the following that describe this Practice Site.</i></p>	<p>Certified Rural Health Clinic (CRHC) Community Health Center (Sec 300 CHC) or "Look-Alike" Community Mental Health Clinic (CMHC) Critical Access Hospital Private For-Profit Clinic Public Clinic (operated by state or local government) Private Not-for-Profit Clinic Tribal-Managed Health Facility Hospital Hospital-Affiliated Clinic Local Health Department Long-Term Care Facility Prison (Adult Corrections) Prison (Juvenile Justice Detention or Treatment) State Psychiatric Hospital Other</p>
<i>If you checked "Other," provide specifics:</i>	
If your answers to this section need further detail, please write your comments here:	

Part C – Experience (Direct Incentive applicants only)

*Present chronology of directly relevant clinical work experience
Copy page as needed for additional positions*

Position Title #2	
Name of Practice/Agency	
Position Dates	
Position Total Years	
Clinical or Admin. Supervisor	
Supervisor Email	
Supervisor Phone	
Brief Practice Description	
State how this Position/ Background is relevant to you being categorized as "Highly Experienced"	
<p>Site Type</p> <p><i>Check ALL of the following that describe this Practice Site.</i></p>	<p>Certified Rural Health Clinic (CRHC) Community Health Center (Sec 300 CHC) or "Look-Alike" Community Mental Health Clinic (CMHC) Critical Access Hospital Private For-Profit Clinic Public Clinic (operated by state or local government) Private Not-for-Profit Clinic Tribal-Managed Health Facility Hospital Hospital-Affiliated Clinic Local Health Department Long-Term Care Facility Prison (Adult Corrections) Prison (Juvenile Justice Detention or Treatment) State Psychiatric Hospital Other</p>
<i>If you checked "Other," provide specifics:</i>	
If your answers to this section need further detail, please write your comments here:	

Part C – Experience (Direct Incentive applicants only)

*Present chronology of directly relevant clinical work experience
Copy page as needed for additional positions*

Position Title #3	
Name of Practice/Agency	
Position Dates	
Position Total Years	
Clinical or Admin. Supervisor	
Supervisor Email	
Supervisor Phone	
Brief Practice Description	
State how this Position/ Background is relevant to you being categorized as "Highly Experienced"	
<p>Site Type</p> <p><i>Check ALL of the following that describe this Practice Site.</i></p>	<p>Certified Rural Health Clinic (CRHC) Community Health Center (Sec 300 CHC) or "Look-Alike" Community Mental Health Clinic (CMHC) Critical Access Hospital Private For-Profit Clinic Public Clinic (operated by state or local government) Private Not-for-Profit Clinic Tribal-Managed Health Facility Hospital Hospital-Affiliated Clinic Local Health Department Long-Term Care Facility Prison (Adult Corrections) Prison (Juvenile Justice Detention or Treatment) State Psychiatric Hospital Other</p>
<i>If you checked "Other," provide specifics:</i>	
If your answers to this section need further detail, please write your comments here:	

Part C – Experience (Direct Incentive applicants only)

*Present chronology of directly relevant clinical work experience
Copy page as needed for additional positions*

Position Title #4	
Name of Practice/Agency	
Position Dates	
Position Total Years	
Clinical or Admin. Supervisor	
Supervisor Email	
Supervisor Phone	
Brief Practice Description	
State how this Position/ Background is relevant to you being categorized as "Highly Experienced"	
Site Type <i>Check ALL of the following that describe this Practice Site.</i>	Certified Rural Health Clinic (CRHC) Community Health Center (Sec 300 CHC) or "Look-Alike" Community Mental Health Clinic (CMHC) Critical Access Hospital Private For-Profit Clinic Public Clinic (operated by state or local government) Private Not-for-Profit Clinic Tribal-Managed Health Facility Hospital Hospital-Affiliated Clinic Local Health Department Long-Term Care Facility Prison (Adult Corrections) Prison (Juvenile Justice Detention or Treatment) State Psychiatric Hospital Other
<i>If you checked "Other," provide specifics:</i>	
If your answers to this section need further detail, please write your comments here:	

Part D – Questions (All applicants)

Please describe those aspects of your personal, academic and/or employment history that you believe make you highly suited to provide healthcare to Alaska's underserved populations. *(limit 150 words)*

Please feel free to provide any other comments that you believe will help SHARP to determine your eligibility and priority for this support-for-service program. *(limit 150 words)*