



**WEST RIVER HEALTH SERVICES**  
**We're right where you need us.**

**LOAN APPLICATION  
FOR HEALTH CARE PROFESSIONALS**

1) Full Name: \_\_\_\_\_  
Last First Middle

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Current Mailing Address:

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

2) Permanent address and telephone number of person through whom you can be located (parent relative, friend, etc.).

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

3) Have you, or will you have any other service obligations that will conflict with the service obligation incurred under this loan? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you received monies from a Federal loan or grant? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, are any of these loans in default? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

4) Name of professional degree program, certification program or educational program:

\_\_\_\_\_

5) Name and location of the college or university where you are enrolled: \_\_\_\_\_

6) Indicate expected month and year you will complete your degree requirements: \_\_\_\_\_

7) Are you enrolled as a full-time student as defined by your college or university? Yes \_\_\_ No \_\_\_

8) Anticipated costs: Tuition \_\_\_\_\_  
Fees \_\_\_\_\_  
Books \_\_\_\_\_  
Other \_\_\_\_\_  
  
Total \_\_\_\_\_

9) Have you ever been employed in health related activities? Yes \_\_\_ No \_\_\_

If yes indicate type and location of work. \_\_\_\_\_  
\_\_\_\_\_

10) Who contributes the major portion of your support?

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

11) List two references and please have your references attach a letter of recommendation to this application.

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to you \_\_\_\_\_ Professional position \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to you \_\_\_\_\_ Professional position \_\_\_\_\_

I hereby certify that the answers given herein are true and correct. I authorize investigation of all statements contained in this application and agree to reference checks as may be deemed necessary to verify any and all information.

I understand that the purpose of this loan program is to provide health care professionals to practice in the West River Health Services service area. My intention is to practice my profession in the West River Health Services service area.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Please return this application, no later than June 1<sup>st</sup> to:

**Bev Strand**  
**Academic Loan Coordinator**  
**West River Health Services Foundation**  
**1000 Highway 12**  
**Hettinger, ND 58639**