

Internship / Residency / Post-Resident Service Obligation  
**Self-Certification Form**  
For Primary Care Loans Made On or After 03/23/10

**Failure to complete and return this form on an ANNUAL basis may result in an increased interest rate and an abbreviated repayment plan. Please remember that you must continue practicing in Primary Care until your PCL loan is paid in full. Please return this form annually by June 30.**

We recommend that you read your promissory note carefully in order to become familiar with a number of features, duties and more specifically, what (is) and what (is not) available relating to the PCL agreement.

Agreement...to enter and practice primary health care within 4 years after the date of graduation.

Agreement...practice primary care until PCL is paid in full.

Agreement...primary care is defined as family medicine, general internal medicine, general pediatrics, preventative medicine or osteopathic general practice.

Agreement...residency training program in PHC is defined as a 3-year residency program in all allopathic or osteopathic family medicine, internal medicine, combined medicine/pediatrics or preventative medicine.

Agreement...Non-Compliance, I understand, if I am not practicing primary health care as defined above as a required part of the Primary Care Loan Program, interest will accrue at a **rate of 7%** from the date of non-compliance.

School: Medical College of Wisconsin: (414) 955-8172

Name \_\_\_\_\_

Street \_\_\_\_\_

City, State Zip \_\_\_\_\_

Last Four Digits of SSN: \_\_\_\_\_

**Please check one of the following:**

[  ] This is to certify that I am and will be practicing Primary Health Care as defined above for the next twelve months. I understand that I must inform my school of my status annually until my PCL is paid in full.

[  ] This is to certify that I am **no longer** practicing Primary Health Care as defined above and as required part of the Primary Care Loan agreement and program, **effective date** \_\_\_\_\_.

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Residency/Practice Address

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

\_\_\_\_\_  
Work Phone Number

Borrower Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Return to:

Medical College of Wisconsin  
Attn: Office of Students Accounts  
8701 Watertown Plank Road  
Milwaukee, WI 53226-0000

mcwtuition@mcw.edu