



Florida Reimbursement Assistance for Medical Education | FRAME

Primary Care/Mental Health

Application

Please type or write legibly. Any illegible field will make this form incomplete.

SECTION 1. Applicant Information

1.01 Name: Last:		1.02 First:		1.03 Middle:	
1.04 Mailing Address:		Street Address or PO Box			
City	State	ZIP Code	County		
1.05 Physical Address:		Street Address			
<input type="checkbox"/> Same as the mailing address (if yes, go to phone #)					
City	State	ZIP Code	County		
1.06 Telephone Number:		1.07 Email Address:			
1.08 Date of Birth:		1.09 Social Security Number ¹ :			
1.10 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		1.11 Ethnicity: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other			
1.12 Please select one: <input type="checkbox"/> I am a US Citizen OR <input type="checkbox"/> I am a US national, as defined by 8 U.S.C. 1401					
1.13 I am licensed as: (select only one) <input type="checkbox"/> Licensed Practical Nurse ² (LPN) <input type="checkbox"/> Registered Nurse ² (RN) <input type="checkbox"/> Advanced Practice Registered Nurse ² (APRN) <input type="checkbox"/> Autonomous Practice APRN ² <input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Physician (MD, DO) <input type="checkbox"/> Psychologist <input type="checkbox"/> Clinical Social Worker <input type="checkbox"/> Marriage & Family Therapist <input type="checkbox"/> Mental Health Counselor					
1.14 I provide direct patient care in the primary care field of: ³ (select only one) <input type="checkbox"/> Family/General Practice <input type="checkbox"/> Gynecology <input type="checkbox"/> Pediatrics (general) <input type="checkbox"/> Internal Medicine (general) <input type="checkbox"/> Obstetrics (general) <input type="checkbox"/> Psychiatry (MD/DO only) <input type="checkbox"/> Geriatrics <input type="checkbox"/> Mental Health					
1.15 License Number:		1.16 Medicaid Provider Number:			
1.17 National Provider Identifier (NPI) Number:		1.18 If none, why?			

¹ **NOTICE OF COLLECTION, USE, OR RELEASE OF SOCIAL SECURITY NUMBERS** - Florida law requires agencies that collect an individual's social security number to state in writing the purpose for its collection. The Department of Health is authorized to collect your social security number pursuant to section 119.071(5)(a)2., Florida Statutes, because collection is imperative for the performance of the Department's duties and responsibilities as prescribed by law. This notice is provided pursuant to section 119.071(5)(a), Florida Statutes. For the FRAME program, established pursuant to sections 381.4019 and 381.402, Florida Statutes, social security numbers are collected and used only for identification purposes and to ensure that loan reimbursement awards are properly applied to the correct individual's qualified loan with a financial institution. Social security numbers collected for this purpose will remain confidential.

² If you received an award from any other State of Florida-funded student loan repayment program since July 1 of the previous year you are not eligible for FRAME. This includes, but is not limited to, the loan reimbursement program offered by the Florida Department of Education.

³ If you are not actively practicing primary care, you are not eligible for this program.

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Applicant Name: _____

1.19 Select one of the following boxes:

☐ I have never received FRAME award.

☐ This is a recertification as I received a FRAME award in the immediately preceding application calendar year.

☐ I have previously received a FRAME award, but not in the immediately preceding application calendar year.

SECTION 2. Loan Payment Preference

You may skip this section if you are requesting loan reimbursement from only one lender, even if you have multiple loans with your lender.

2.01 The number of educational loan lenders: _____

2.02 Please specify what portion of the allowable amount you wish to be applied to each lender you have a loan with.

Payment Preference	Lender	Principal Balance	Portion of Allowable Amount to be applied
1 st Preference		\$	%
2 nd Preference		\$	%
3 rd Preference		\$	%

SECTION 3. Attestations

I hereby attest that all information and statements contained herein are true and do not misrepresent facts. I further attest that I have not evaded or suppressed any information contained in this application or any of the supporting materials. The information I have supplied on this application is complete, true, and accurate. To the best of my knowledge and belief, I am eligible for this program.

Furthermore, I attest that I am not currently receiving student loan repayment from a different state of Florida agency, that I have not applied to receive student loan repayment from a different state of Florida agency, nor do I intend to apply for student loan repayment from a different state of Florida agency.

Applicant's Signature

Date

Applicant's Printed Name

Please Note: Your application will not be considered complete in the FRAMEworks portal without submitting complete Employment Verification Form(s), Loan Certification Form(s), HPSA documentation, or Volunteer Hours Verification Forms, and entering information from those forms into the application portal.

NOTICE: Any person who knowingly makes a false statement or misrepresentation on this form is subject to penalties under section 837.06, Florida Statutes, which may include fines, imprisonment, or both.