Loan Repayment Qualifying Education Loan Payment Confirmation

Health Care Provider Incentives Program

Tina Kotek, Governor

OREGON HEALTH AUTHORITY
OREGON OFFICE of RURAL HEALTH
ORH

Please complete this form as requested by ORH, in compliance with the OHA Health Care Provider Incentive Program under OAR 409-036. Inaccurate or incomplete information may result in delays in payment processing.

Provider name: _____

Contract number: _____

I, [_____], confirm that:

- I have applied the full amount of my _____(ex: April 2025) Oregon Health Care Provider Loan Repayment disbursement in the amount of $_____ toward my **qualifying educational loans; AND**
- I have attached a payment history document from my loan provider showing that the disbursement amount above was applied to my **qualifying educational loans**.

Please complete the table below with the date and amount of each payment made using this award disbursement.

Table 1. Payments applied from this quarters disbursement

Payment #	Date of Payment	Amount Paid
Payment 1	Date:	Amount:
Payment 2	Date:	Amount:
Payment 3	Date:	Amount:
Payment 4	Date:	Amount:

Total Amount Applied from Disbursement:

Note: The total amount applied must equal the total disbursement received.

_____
Provider Signature

_____ _____
Printed Name Date

For ORH office use only: ___ of 12