Florida Reimbursement Assistance for Medical Education (FRAME) | Application

SECTION I. Applicant Information

Name: Last:	First:	Middle:	
Mailing Address:	Street Address or PO Box		
City	State	ZIP Code	County
Physical Address: ☐ Same as the mailing address (if yes, go to phone #)	Street Address		
City	State	ZIP Code	County
Telephone Number:	Email Address:		
Date of Birth:	Social Security Number:		
Gender: ☐ Male ☐ Female	Ethnicity: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Native American ☐ Other		
Please select one: ☐ I am a US Citizen OR ☐ I am a US national, as defined by 8 U.S.C. 1401			

Provider Type (select only one):

☐ Licensed Practical Nurse (LPN) ☐ Registered Nurse (RN) ☐ Advance Practice Registered Nurse (APRN)
☐ Autonomous Practice APRN ☐ Physician Assistant (PA) ☐ Physician (MD, DO)

Specialty (select only one)

☐ Family/General Practice ☐ Gynecology ☐ Pediatrics (general)
☐ Internal Medicine (general) ☐ Obstetrics ☐ Psychiatry
☐ Other (option only for LPN, RN, and PA) Specify:

Medical License Number:	National Provider Identifier (NPI) Number:(if applicable)	Medicaid Provider Number: (if applicable)

SECTION II. Lender Information

The number of educational loan lenders: ☐

If you have 2 or more US-based educational loan lenders, please specify which lenders you have loans with, and how much you would like paid on each loan. Please be sure your total amount to be paid does not exceed the maximum allowed for your provider type.

Lender:	Principal Balance: $	Amount to be paid: $
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Max amounts to be paid by provider type: $4,000 for LPN and RN; $10,000 for APRN and PA; $15,000 for autonomous practice APRN; and $20,000 for physicians.

SECTION III. Educational Information

Please provide the information below for each certification or degree completed.

Educational Level	Completion Date	Institution Name	Institution City	Institution Country	Institution State
High School					
Certification					
Associate's Degree					
Bachelor's Degree					
Master's Degree					
Doctorate Degree					
Medical Degree					
Other					

SECTION IV. Employment Information

In what year did you first begin practicing in Florida? ☐

How long have you practiced in a federally-designated HPSA located in Florida? ☐ years, ☐ months

Please select one:

- ☐ I am an employee. Complete Employment Verification Form
- ☐ I am in a practice with others, but not an employee. Complete Solo Practitioner Attestation.
- ☐ I am a solo practitioner. Complete Solo Practitioner Attestation.

SECTION V. 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 a state of Florida funded student loan repayment, that I have not applied to receive a state of Florida funded student loan repayment, nor do I intend to apply for a different state of Florida funded student loan repayment.

Applicant's Signature	Date	Applicant's Printed Name

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.