



OFFICE OF PUBLIC HEALTH NURSING

NURSING STUDENT LOAN FORGIVENESS PROGRAM

APPLICATION PACKAGE

CONTAINS: NURSING STUDENT LOAN FORGIVENESS
PROGRAM CONDITIONS, APPLICATION,
EMPLOYMENT VERIFICATION, AND LOAN
PRINCIPAL CERTIFICATION

**DEPARTMENT OF HEALTH
OFFICE OF PUBLIC HEALTH NURSING
NURSING STUDENT LOAN FORGIVENESS PROGRAM**

**PROGRAM CONDITIONS
IMPORTANT: PLEASE READ AND RETAIN FOR YOUR RECORDS**

The Florida Legislature created the Nursing Student Loan Forgiveness Program (NSLFP) in 1989, to encourage qualified personnel to seek employment in areas of the state where there are critical nursing shortages. It is authorized under section 1009.66, Florida Statutes (F.S.). The purpose of the program is to increase employment and retention of nursing personnel at designated/eligible sites or facilities in Florida.

Funding for the NSLFP is contingent upon available moneys in the Nursing Student Loan Forgiveness Trust Fund. Enrollment in the NSLFP is made based on the receipt date of a completed application, by the established deadline, consistent with the priorities, as specified in section 1009.66(7)(a), F.S.

A nurse may apply for enrollment after becoming employed full-time at a designated/eligible site/facility. Nurses employed in a contract, per diem, pool, agency staffing or part-time capacity, etc., are not eligible.

AFTER ENROLLMENT IN THE PROGRAM, YOU MUST CONTINUE TO MAKE LOAN PAYMENTS IN ACCORDANCE WITH THE SCHEDULE AGREED UPON WITH YOUR LENDER(S).

ELIGIBILITY:

All applicants must:

- Have graduated from nursing school;
- Be currently licensed or certified by the Florida Board of Nursing as a Licensed Practical Nurse (LPN), a Registered Nurse (RN), or an Advanced Registered Nurse Practitioner (ARNP);
- Have outstanding current student loan(s) incurred toward a nursing education;
- Not be in default status, or have been in default status on the nursing student loan(s);
- Not have participated in the Nursing Scholarship Program; and,
- Be employed full-time, as a nurse, at a designated/eligible site or facility in Florida.
- Maintain full-time employment for each consecutive employment year, at the site or facility you are employed at when you are enrolled into the program. Changing employer or changing to part-time employment, while enrolled in the program, nullifies the agreement. You may re-apply after becoming employed full-time at another eligible site or upon regaining full-time employment status.

APPLICATION PROCEDURES:

All applicants must:

- Submit the NSLFP Application Package which consists of the: Application; Attachment 1, Employment Verification; and Attachment 2, Loan Principal Certification to the department, by the deadline date for the quarter in which the applicant is seeking enrollment. Enrollment is made quarterly, as funds are available.

- Referring to Attachment 1, Employment Verification, full-time employment shall be those hours, determined by the employer, to be one full-time equivalent (1.0 FTE) position.
- Provide a photocopy of your diploma from an accredited or approved nursing program (optional).
- **Renewal:** In order to continue in the NSLFP, a Renewal Application and Attachment 2, Loan Principal Certification, is mailed to each program participant approximately 30 days before the end of each employment year. It must be returned in the time frame indicated.
- **Annual Payment:** In order for the annual payment to be made on behalf of a program participant, a Loan Principal Repayment Invoice is also mailed approximately 30 days before the end of each employment year. It also must be returned in the time frame indicated.

APPLICATION TIME FRAMES FOR EACH QUARTER ARE:

November 1 - December 1

February 1 - March 1

May 1 - June 1

August 1 - September 1

- Completed applications must be received by the deadline date for enrollment.

PAYMENT:

- A **Loan Principal Repayment Invoice** is mailed to program participants by the department, approximately 30 days before the end of each employment year. The Loan Principal Repayment Invoice is the document that initiates the annual payment. It must be signed and dated by both the program participant and the program participant's immediate supervisor, and returned in the time-frame indicated, verifying the program participant's full-time employment and provision of satisfactory nursing care for that employment year.
- The department will send a payment to the program participant's lender following each complete year of full-time employment, for a maximum of four years. Each payment is toward the **LOAN PRINCIPAL ONLY** of the outstanding student loan principal payoff amount, provided by the lender(s) on Attachment 2, Loan Principal Certification. Payment is remitted by a state warrant payable to the lender only. The payment amount is up to \$4,000 annually, for four years toward the principal only of outstanding nursing student loan(s) incurred toward a nursing education. Only loans from state or federal programs or commercial lending institutions are eligible. If a program participant has more than one lender, the principal of the largest loan will be paid first.
- **ALL PAYMENTS** made on behalf of a program participant **ARE TAXABLE**. The Florida Department of Financial Services will notify the Internal Revenue Service of the taxable income received by a program participant. Tax responsibilities must be assumed by the program participant. The State of Florida and the Department of

Health assume no liability for any taxes owed by a program participant. Contact state and federal taxing authorities to determine if taxes are owed.

- **STATE EMPLOYEES:** Federal Income, Social Security and Medicare taxes will be deducted from each payment made on behalf of all nurses participating in the program, who are State of Florida employees. The net amount, after the deductions, is forwarded to the lender. The gross amount will be reflected in the annual State Employee Earnings Statement.
- **NON-STATE EMPLOYEES:** Taxes are not deducted for program participants who are not employed by the State of Florida and are responsible for paying any taxes incurred as a result of participation in the program. The gross payment amount is forwarded to the lender. The Florida Department of Financial Services will annually mail a Form 1099 to you for tax purposes and notify the Internal Revenue Service of the amount of the payment.
- Program participants are responsible for paying any service fees or late charges that may be imposed by the lender(s). Any other costs or fees (including accrued interest) assessed by the lender(s) are the responsibility of the program participant.
- No program participant will be continued in the NSLFP once 100% of the verified loan principal balance has been resolved, or four years of participation have concluded, **whichever occurs first.**

*Florida Department of Health
Office of Public Health Nursing
Nursing Student Loan Forgiveness Program
4052 Bald Cypress Way, Bin C-27
Tallahassee, Florida 32399-1708*

Telephone Numbers:
*Toll-free: 800-342-8660
Local: 850-245-4444 x3503*



NURSING STUDENT LOAN FORGIVENESS PROGRAM APPLICATION

Return to: Department of Health Office of Public Health Nursing 4052 Bald Cypress Way Bin C-27 Tallahassee, FL 32399-1735

This application is for applicants who are licensed or certified by the Florida Board of Nursing and employed full-time in designated/eligible sites/facilities, as qualified by the Florida Department of Health.

APPLICANT'S IDENTIFICATION INFORMATION (please print legibly in ink)

1. Name: Last First MI
2. *Social Security Number: 3. Date of Birth: MM/DD/YYYY
4. Permanent Mailing Address: Street City State Zip County
5. Home telephone number: () - 6. Work telephone number: () -
7. Email Address:
8. Current Florida nursing license number: 9. Type (LPN, RN, ARNP):
10. Name and address of the hospital, medical/health care facility or public school in Florida where you are employed:
Name:
Street City State Zip
11. Immediate supervisor's name and telephone number: () -
Name Telephone number

Although the following information is not mandatory, it is requested to aid the state of Florida in its commitment to develop accurate statistics and reports. Refusal to answer will have no impact on the consideration of your application.

12. Gender: Male Female 13. Race: (Please check only one) White Black Hispanic Asian/Pacific Islander American Indian/Alaskan Native Other
14. Highest Degree Received): Associate's (ADN): Bachelor's (BSN): Master's (ARNP):

NURSING EDUCATION The following education after high school led to my nursing license or certificate:

Table with 4 columns: Name of Institution, City, State, Dates of Attendance, Type of Degree or Certificate

ATTACHMENTS:

As a reminder, the following completed attachments must accompany this Application to be considered for enrollment:

- 1. Attachment 1 – Employment Verification.
2. Attachment 2 – Loan Principal Certification
3. A photocopy of your diploma verifying completion of a nursing program (optional).

APPLICANT'S SIGNATURE OF AGREEMENT

I, the undersigned, have received, understand and agree to the NSLFP conditions. To the best of my knowledge, 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.

Applicant's Signature Date

NOTICE: If you purposely provide false information on this application, you may be subjected to fine or imprisonment or both, under section 837.06, Florida Statutes.

* Providing the SSN is optional. This application will be considered with or without the SSN. Without the SSN, correct identification of an applicant's record cannot be assured and may result in an error in the award amount or delay in disbursement of an award.



ATTACHMENT 1
NURSING STUDENT LOAN FORGIVENESS PROGRAM
EMPLOYMENT VERIFICATION

SECTION I: To be completed by applicant. Please print legibly in ink. Attachment 1 must accompany the application when submitted for enrollment.

Applicant Name: _____ *Social Security Number: _____

I authorize the Human Resources or Personnel Director, or designee, of _____ to certify that I am a full-time employee. (Employing Facility)

Signature of Applicant: _____ Date: _____

SECTION II: To be completed by the Human Resources/Personnel Director, or designee, of the facility where the applicant is employed. Please affix employer's stamp/seal below.

I certify that the above applicant is currently employed full-time (in a 1.0 FTE position), at the above referenced facility, as a nurse.

Employment began on: _____ Signature: _____

Printed Name: _____ Date: _____ Title: _____

Facility: _____

Address: _____ Street _____ City _____ State _____ Zip Code _____

Telephone Number: (_____) _____

SECTION III: MATCH SITE FACILITIES (employer match required)

To be completed only by the employing facility's representative, who is authorized to financially bind the employing facility to the commitment.

- A. ONLY Florida licensed HOSPITALS (other than those specifically identified by name on the separate site list), BIRTH CENTERS and NURSING HOMES, must agree to contribute up to \$2,000, per year, per program participant for the duration of the program's participant's enrollment in the program, which is a maximum of four years.
- The maximum amount a Match Site Facility is required to pay is \$2,000 per year, per program participant.
- The match payment must be received by the Florida Department of Health, Nursing Student Loan Forgiveness Program, for deposit in the Nursing Student Loan Forgiveness Trust Fund before any payment will be made on behalf of the program participant.
- A notice that the match portion is due and a copy of the program participant's Loan Principal Repayment Invoice will be mailed to the individual identified below, approximately 30 days before the end of the program participant's employment year.

B. I fully understand, accept, and agree to the conditions of my facility's contribution to the Nursing Student Loan Forgiveness Trust Fund. I understand I will be notified when the Match Payment is due from this facility. Within 30 days of receipt of notification from the department, this facility will remit up to \$2,000 on behalf of the program participant, each year of eligible participation, for a maximum of four years.

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Facility: _____

Address: _____ Street _____ City _____ State _____ Zip Code _____

Telephone Number: (_____) _____

Employer's Stamp or Seal
REQUIRED Below
Or statement on employer's
letterhead verifying full-time
employment



*Providing the SSN is optional. This form will be considered with or without the SSN. Without the SSN, correct identification of an applicant's record cannot be assured and may result in an error in the award amount or delay in disbursement of an award



ATTACHMENT 2
NURSING STUDENT LOAN FORGIVENESS PROGRAM
LOAN PRINCIPAL CERTIFICATION

SECTION I: To be completed by applicant. Please print legibly in ink. Attachment 2 must accompany the Application, when submitted for enrollment.

Please allow adequate time for the lender(s) to comply with this request and return the form(s) to you. ORIGINAL SIGNATURES ARE REQUIRED, FACIMILES (FAXES) ARE NOT ACCEPTED. If there is more than one loan, an Attachment 2 must be submitted to each lender, for each loan principal to be considered. Attachment 2 may be photocopied as needed. If the loan(s) has/have been sold to another lender or the loans are consolidated, submit Attachment 2 to the current holder of the loan(s), not the original lender. The lender's seal or stamp must be affixed to this form where indicated, or a statement on the lender's letterhead, verifying the current LOAN PRINCIPAL PAYOFF AMOUNT ONLY, must accompany this form. If you are in default status or have been in default status on your nursing student loan(s), you are not eligible for enrollment into the program.

Lender's Name: _____

Address: _____
Street City State Zip Code

Student Loan Pertaining to: _____ *Social Security Number: _____
Name of Borrower

Dear Lender: I have applied to participate in the Florida Department of Health's Nursing Student Loan Forgiveness Program. It assists nurses in repaying the PRINCIPAL ONLY of student loans, incurred toward a nursing education. I hereby authorize you to discuss and/or release any information requested by the Florida Department of Health, Nursing Student Loan Forgiveness Program, regarding my loan(s).

As a condition of the program, I will continue to make payments on my student loan(s), in accordance with my established repayment schedule. In addition to my monthly payments, a check will be forwarded to you, annually, by the Florida Department of Health, Nursing Student Loan Forgiveness Program, to reduce my outstanding student loan PRINCIPAL balance(s) only. Please verify and provide a quote of my current PRINCIPAL PAYOFF AMOUNT ONLY, good for at least 31 days or longer. Please complete Section II on the back of this form, affix your stamp/seal where indicated, and return it to me at the address below. If your company has no stamp/seal, please include a statement on company letterhead, verifying the current loan PRINCIPAL payoff amount only.

Applicant's Name: _____

Address: _____
Street City State Zip Code

Home Telephone Number: (____) ____-____ Signature: _____ Date: _____

LENDER INFORMATION

For program participants in the NSLFP, the Florida Department of Health will mail a state warrant, payable to the lender, after one year of approved employment by the program participant. This payment is to be applied to the outstanding PRINCIPAL ONLY of the participating nurse. If the amount of a payment exceeds the remaining unpaid PRINCIPAL, the lender is authorized to refund the difference to the Florida Department of Health, Nursing Student Loan Forgiveness Program Trust Fund. This program provides a maximum annual payment of \$4,000 per year, for up to four years. NO PAYMENT, OR PORTION OF A PAYMENT, MAY BE APPLIED TOWARD ACCRUED INTEREST ON LOANS.

The applicant is aware that the annual payment has no effect on his/her repayment schedule or obligation to the lender. The applicant is required to continue to make loan payments, as required by the loan agreement.

LENDERS: Please complete and sign Section II, and affix your stamp/seal. This form must be returned to the applicant identified above. If a lender does not have a stamp or seal, the lender must return the completed form to the applicant, with a statement on the lender's letterhead, verifying the current loan PRINCIPAL PAYOFF AMOUNT ONLY.

*Providing the SSN is optional. This form will be considered with or without the SSN. Without the SSN, correct identification of an applicant's record cannot be assured and may result in an error in the award amount or delay in disbursement of an award.



SECTION II: LOAN PRINCIPAL CERTIFICATION (To be completed by the lender or holder of the student loan and must be returned to the nurse identified on the front side of this form).

I certify that this borrower **is not in and has not been in** default status, regarding the referenced loan(s).

Current PRINCIPAL ONLY Pay-off Balance: \$ _____ Good through (Date): _____

Name of Lending Institution: _____

Federal ID Number: _____ (9 digit FEID number)

Remittance Address: _____
Street City State Zip

Signature of Lending Institution Contact: _____

Name/Title of Contact (Print): _____

Telephone Number: (____) _____ - _____ Date: _____

Lender's Stamp or Seal
REQUIRED Below

Or statement on Lender letterhead verifying
principal payoff quote