Loan Repayment Program Quarterly Verification Form

Part A – to be completed by recipient dentist

I certify that I am serving as a licensed dentist at the above address. I attest that I am accepting new Iowa Medicaid insured patients and ____ % of my patient schedule was allocated to Underserved Persons (as defined in the Loan Payment for Service Program Agreement) for the above stated period.

_____	(_____)_____
Name (please type or print)	Telephone number
_____	(_____)_____
Address	Fax number
_____	_____
City/State/Zip	E-mail address
_____	_____
Signature	Date

Part B – to be completed by host dentist (if applicable)

I certify under penalty of perjury that the information stated above is true and correct. The person named above is providing service as a dentist at the above-named facility and is eligible for loan repayment for the above-stated period.

_____	_____
Name (please type or print)	Title
_____	_____
Signature	Date