



Primary Care Practitioner Loan Redemption Program of New Jersey Quarterly Service Report

Provider's Name: _____

Provider's Contract Year: _____

Placement Site: _____

Period Covered: _____

This will confirm that the above provider was present on a full time basis (minimum of 40 hours/week) delivering patient care services at this site for the time period covered in this report with the exceptions of illness, vacation, CME program, and other (specify) noted below:

<u>Inclusive Date</u>	<u>Reasons</u>
_____	_____
_____	_____
_____	_____

For the Provider:

Number of Encounters: _____

For This Placement Site:

Number of Encounters: _____

For the Provider:

Number of Patients: _____

For This Placement Site:

Number of Patients: _____

The placement site data is a mandatory requirement and an essential aspect in the evaluation of the impact of the Loan Redemption Program (LRP). Participants will not receive loan repayments until all Quarterly Service Reports are received by the LRP. Your prompt response and cooperation are greatly appreciated. Please return the completed form to:

**Higher Education Student Assistance Authority
Primary Care Practitioner Loan Redemption Program
4 Quakerbridge Plaza
P.O. Box 544
Trenton, NJ 08625-0544**

Name: _____ Signature: _____

Title: _____ Phone Number: _____