Washington State Health Professional Loan Repayment Program

DEFERMENT REQUEST FORM

The purpose of this form is to request a deferment from service. Staff will review the form to determine if the participant is eligible or not eligible for deferment.

LOAN REPAYMENT PARTICIPANT

Last Name ____________________ **First Name** ____________________

Email ____________________

Current Site(s) Name ____________________

Additional Site Name ____________________

DEFERMENT REQUEST DETAILS

Start Date of Leave ____________________

End Date of Leave ____________________ (If end date is unknown at this time, write "unknown")

Type of Leave ☐ FMLA ☐ Medical Leave ☐ Active Military Service ☐ Jury Duty

☐ Other - explain ____________________

Additional Information: ____________________

☐ I certify that the information contained in this request is true and accurate and agree to submit additional documentation if requested.

Participant Signature ____________________

Date ____________________

SITE REPRESENTATIVE CERTIFICATION

☐ I certify that the information contained in this request is true and accurate.

Authorized Site Representative Signature ____________________

Title ____________________

Date ____________________

Email ____________________

PROGRAM STAFF ONLY

Deferment Approved ☐ Yes ☐ No *If no – see reason in "Notes"*`

Notes ____________________

Approved Dates ________ to ________

Number of Days Away ________ (based on 8-hour day calculation)

Contract Amendment Received ☐ Yes ☐ N/A *(requirement for FSLRP)*

Staff Signature ____________________

Date ____________________

Submit completed form via mail, fax, or email to Washington Student Achievement Council at:

Mail: PO Box 43430, Olympia WA 98504-3430 • **Fax:** 1-866-381-1094 • **Email:** health@wsac.wa.gov

Phone: 1-888-535-0747 option 5

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