ARKANSAS DEPARTMENT OF HIGHER EDUCATION
114 E. Capitol Little Rock, AR 72201
501.371.2000 Fax 501.371.2001

ARKANSAS HEALTH EDUCATION GRANT (ARHEG) PROGRAM

DENTAL LOAN FORGIVENESS VOUCHER

Notice of Intent to Seek Loan Forgiveness for:

Loan Year: _____ **Amount of Loan:** $_____

PLEASE PRINT OR TYPE

NAME: _____ **SSN** _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: (_____)_____

COLLEGE OF DENTISTRY: _____

GRADUATION DATE: _____

AR LICENSE #: _____ **DATE RECEIVED:** _____

EMPLOYMENT INFORMATION

EMPLOYER: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _(_____)_____**EMAIL:** _____

SERVICE DATES (dd/mm/yyyy)

FROM: _____ **TO:** _____

(over)

ARKANSAS DEPARTMENT OF HIGHER EDUCATION

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DENTAL LOAN FORGIVENESS

The following Notarization of Affidavit must be signed in the presence of a commissioned notary public and affixed with his or her seal.

Notarization of Affidavit

The undersigned, being first duly sworn upon his or her oath says that each and severally the answers and statements made above are true and correct to the best of his or her knowledge and belief.

By my signature, I attest that _____ has been in my employment for one (1) full year of uninterrupted service as required by the Agreement for **Loan Year 2003-04.**

Signature of Employer: _____

By my signature, I, _____, attest that the information I have provided is complete and correct, and that one (1) year of my loan is forgiven for one (1) year of uninterrupted service of dentistry to the State of Arkansas.

_____ _____

Signature of Recipient Date

Subscribed and sworn before me this _____ day of _____, 20_____

Signature of Notary Public: _____

My Commission Expires: _____ 20_____