

**Residency Incentive Program Application**  
***Answers to all questions are required, otherwise your application is incomplete  
Applications with supporting documents are accepted year-round and are reviewed regularly.***

**Date:**

**Name:**

**Address [street number, city, state, zip]:**

**Primary Phone Number: Alternate Phone Number:**

**E-mail Address:**

**Alternate E-mail Address:**

**Medical School: Graduation Date: Degree:**

**Residency Program (Name and Location):**

**Specialty: Start Date: Anticipated Completion Date:**

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**TCWD does not “assign” you to practice locations but you are required to fulfil your practice obligation in a medically underserved area/practice. Please explain any restrictions regarding practice locations.**

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**Are you already required to fulfill any type of service obligation?**   
🞏 Yes 🞏 No  
If yes, what type?  
🞏 National Health Service Corps  
🞏 State Loan Repayment Program  
🞏 Other [Specify] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obligation length\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about the TCWD Residency Incentive Program?**

🞏 TCWD Exhibit at Meeting/Convention [Specify which meeting/convention]

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🞏 Other [Specify] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 TCWD Web Site  
🞏 From a Stipend Recipient  
🞏 TCWD Staff Visited My Residency Program  
🞏 Residency Program Faculty

**Personal Statement:   
Please use this space to explain your connection and commitment to practice in a medically underserved area of Tennessee. Tell us what type of practice you prefer. Be sure to address any gaps or extensions taken in medical school or residency – applications without an explanation will be deemed incomplete. Also, tell us why participating in TCWD's Residency Incentive Program is of interest to you. Please provide examples of your experiences and commitment to providing care to medically underserved populations.** *Take as much space as you wish, but a full page is recommended. Feel free to attach a separate document for this portion of the application.*

**\*Continue to Page Three\***

**In addition to this application form,** **please provide TCWD with the following additional documents. Your application will not be complete and cannot be reviewed until all supporting documentation is received.**

Send the following to [djayroe@tha.com](mailto:djayroe@tha.com) or by mail to:   
Tennessee Center for Health Workforce Development

Attn: Physician Residency Incentive  
5201 Virginia Way  
Brentwood, TN 37027

1. A letter from your program director supporting this application, indicating your good standing in the residency program, and giving their opinion about your suitability for practice in a medically underserved practice site.

2. A copy of your CV.

3. Final medical school transcript (sent directly by the medical school to TCWD at the address above).

4. Evidence of citizenship (copy of birth certificate, certificate of naturalization or permanent resident status).

5. Evidence of an unrestricted Tennessee medical license OR evidence of passage of all components of the USMLE or COMLEX and eligible for Tennessee licensure upon completion of residency program. [You may be awarded a stipend prior to passage of all steps, but results must be shared with TCWD when all components are completed.]