



# **Nursing Student Loan Forgiveness Program Application Package**

Nursing Student Loan Forgiveness Program Information, Initial Application,  
Employment Verification and Loan Principal Certification

Florida Department of Education  
Office of Student Financial Assistance  
325 West Gaines Street, Suite 1340  
Tallahassee, Florida 32399-0400

Email: [Connie.Rowland@fldoe.org](mailto:Connie.Rowland@fldoe.org)  
850-245-1962

[www.FloridaStudentFinancialAid.org](http://www.FloridaStudentFinancialAid.org)

## About the Nursing Student Loan Forgiveness Program

The Florida Legislature created the Nursing Student Loan Forgiveness Program (NSLFP) in 1989, to encourage qualified personnel to seek employment in areas of the state where there are critical nursing shortages. It is authorized under Section [1009.66](#), Florida Statutes (F.S.) and [6A-20](#), Florida Administrative Code (F.A.C.). The purpose of the program is to increase employment and retention of nursing personnel at designated sites or facilities in Florida.

*Based on available funds, the program provides up to \$4,000 a year for a maximum of four years to assist in the payment of the principal balance of the originally verified nursing education loan. After one year of program enrollment, participants will receive a renewal packet. Initial payment will be made to the lender once full-time employment and loan principal balance are verified. Awards are not taxable, pursuant to the Affordable Care Act of 2010.*

### Eligibility Requirements

#### **You ARE eligible to apply if you:**

- Have graduated from an accredited or approved nursing program;
- Are licensed by the Florida Board of Nursing as a Licensed Practical Nurse (LPN), Registered Nurse (RN) or an Advanced Practice Registered Nurse (APRN);
- Have outstanding qualifying student loans from a federal, state or commercial lending institution, incurred toward an obtained nursing degree or nursing certificate; and
- Work **full-time** as a nurse at a designated site in Florida. Full-time employment shall be those hours determined by the employer to be one full-time equivalent (1.0 FTE) position.

#### **You are NOT eligible to apply if you:**

- Currently have a student loan *in default status*;
- Work in a contract on an “as needed” basis (PRN, pool nurses, agency nurses), part-time or self-employed capacity; or
- Previously participated in the Florida Nursing Scholarship Program.

### Selection Criteria – Acceptance is based on the following:

- **Available Funds**  
Funding for the NSLFP is contingent upon available funds in the Nursing Student Loan Forgiveness Trust Fund.
- **Designated Site Category (s. [1009.66](#), F.S.)**  
Applicants are selected for program enrollment in the following order of priority:
  1. State of Florida operated medical and health care facilities
  2. Florida Public schools (direct care provider)
  3. Florida Department of Health, county health departments
  4. Federally sponsored community health centers
  5. Teaching hospitals
  6. Family practice teaching hospitals
  7. Specialty hospitals for children
  8. Match site facilities - Florida licensed hospitals (other than teaching hospitals and specialty hospitals for children), birth centers and nursing homes must be matched on a dollar-for-dollar basis by contributions from the employing institutions.
- **Receipt Date of Applications**  
Applications must be received by the Office of Student Financial Assistance by the quarterly enrollment deadline. Only complete applications received by the deadline will be considered for enrollment.

### Application Timeframes for Each Quarter

APPLICATION TIMEFRAMES	DEADLINE	ENROLLMENT DATE
February 1 - March 1	March 1	April 1
May 1 - June 1	June 1	July 1
August 1 - September 1	September 1	October 1
November 1 - December 1	December 1	January 1

### Application Procedures

**All applicants must submit the following by mail:**

- NSLFP Initial Application
- Employment Verification Form
- Loan Principal Certification Form
- Legible copy of nursing diploma/degree
- Legible copy of current nursing license

**Mail completed application and supporting documents to the following address:**

Florida Department of Education  
Office of Student Financial Assistance  
Nursing Student Loan Forgiveness Program  
325 West Gaines Street, Suite 1340  
Tallahassee, Florida 32399-0400

**When your application is received by the Office of Student Financial Assistance:**

- The application is date stamped and reviewed for completeness.
- All complete applications will be processed based on the "Selection Criteria" on page 2.

**If you are selected for enrollment:**

- A program acceptance letter will be emailed to you.
- You will be required to work one full year from your enrollment date with no break in service (i.e., greater than 31 days) before a payment is disbursed to your lender, on your behalf.
- Approximately 30 days before your yearly enrollment anniversary, an email will be sent to you with a link to the Renewal Packet. These forms must be completed and mailed by the indicated timeframe to the address above. Upon verification of requirements, an initial payment will be made to your lender.

**If you are not selected for enrollment:**

- An email will be sent to you stating the reason you were not selected as a participant.
- You may reapply during any future application timeframe.

## Initial Application Instruction Sheet

### NURSING STUDENT LOAN FORGIVENESS PROGRAM INITIAL APPLICATION (Form NSLF-1)

#### APPLICANT'S IDENTIFICATION INFORMATION

1. **Name:** Enter your legal name.
  2. **Home Mailing Address:** Enter your current address.
  3. **Primary Telephone Number:** Enter your primary contact number.
  4. **Date of Birth:** Enter your date of birth.
  5. **Social Security Number:** Enter SSN (required). SSN assists with identification and timely processing.
  6. **E-mail Address:** Enter current e-mail address.
  7. **Nursing License Number:** Enter current nursing license number. Provide a legible copy of license.
  8. **License Type:** Check the box that corresponds with your license type.
  9. **Employer and Position Title:** Enter the name of your employer and your position title.
  10. **Work Site (Name and Physical Address):** Enter the qualified work site name, address and telephone number.
  11. **Immediate supervisor's name and telephone number:** Enter immediate supervisor's name and telephone number.
  - 12-14. **Statistical Data:** For statistical purposes, not mandatory.
  15. **Nursing Education:** Enter degree/diploma information. Provide a legible copy of degree/diploma.
- 

#### EMPLOYMENT VERIFICATION (Form NSLF-2)

**Section I: AUTHORIZATION:** Enter social security number, print name, sign name and enter date.

**Section II: VERIFICATION:** To be completed by immediate supervisor or human resources department.

**Section III: MATCH SITE FACILITIES:** To be completed ONLY if a match is required.

---

#### LOAN PRINCIPAL CERTIFICATION (Form NSLF-3)

Complete **Section I** and send form to lender to complete Section II.



**NURSING STUDENT LOAN FORGIVENESS PROGRAM (NSLFP)  
INITIAL APPLICATION**

**REMINDER:** The following documents must be submitted with Initial Application: Employment Verification, Loan Principal Certification, photocopy of diploma/degree and nursing license.

**APPLICANT'S IDENTIFICATION INFORMATION** (please print legibly in ink)

1. Name \_\_\_\_\_  
Last First MI

2. Home Mailing Address \_\_\_\_\_  
Street or PO Box City State Zip Code County

3. Primary Telephone Number (\_\_\_\_\_) \_\_\_\_\_ 4. Date of Birth \_\_\_\_\_ 5. Social Security Number \_\_\_\_\_

6. E-mail Address \_\_\_\_\_

7. Current Nursing License Number \_\_\_\_\_ (Attach a copy of nursing license) 8. License Type LPN ☐ RN ☐ APRN ☐

9. Employer and Applicant Position Title \_\_\_\_\_ 10. Work Site (Name and Physical Address) \_\_\_\_\_

Name \_\_\_\_\_  
Applicant Position Title \_\_\_\_\_

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
(\_\_\_\_\_) \_\_\_\_\_ Telephone Number \_\_\_\_\_

11. Immediate Supervisor Name \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Questions 12-14 are not mandatory. This information is requested to aid the state of Florida in its commitment to develop accurate statistics and reports. Refusal to answer will have no **impact** on the consideration of your application.

12. Sex Male \_\_\_\_\_ Female \_\_\_\_\_ 13. Race (Please check only one) American Indian or Alaska Native \_\_\_\_\_ Asian \_\_\_\_\_  
Black or African American \_\_\_\_\_ Native Hawaiian or Pacific Islander \_\_\_\_\_ White \_\_\_\_\_ Other \_\_\_\_\_

14. Ethnicity: Hispanic \_\_\_\_\_ Non-Hispanic \_\_\_\_\_

**15. NURSING EDUCATION** The questions below relate to the nursing degree/diploma obtained, for which award will be applied.

- A. Provide the name of the accredited nursing program/school you attended. \_\_\_\_\_
- B. Indicate degree obtained. ASN ☐ BSN ☐ MSN ☐ Other \_\_\_\_\_ or Diploma ☐
- C. Provide a copy of the nursing degree/diploma indicated above.

**APPLICANT'S SIGNATURE OF AGREEMENT**

I, the undersigned, have received, understand and agree to the NSLFP conditions. To the best of my knowledge, the information I have supplied on this application is complete, true and accurate. To the best of my knowledge and belief, I am eligible for this program.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Notice: Section 837.06, Florida Statutes, False official statements.** —Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.



**NURSING STUDENT LOAN FORGIVENESS PROGRAM (NSLFP)  
EMPLOYMENT VERIFICATION**

**SECTION I: AUTHORIZATION** (To be completed by applicant. Please print legibly in ink.)

I authorize my supervisor or a representative from the human resources department to certify that I am employed as a **full-time** (in a 1.0 FTE position) nurse. My Social Security Number is \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION II: VERIFICATION** (To be completed by supervisor or human resources department.) Affix employer's stamp/seal below or employer verification on letterhead, in addition to this form. - REQUIRED

I certify that the above applicant is employed full-time (in a 1.0 FTE position) at the work site below, providing nursing care, and is not employed in a contract "as needed" basis (PRN, pool-nurse, agency nurse), part-time or self-employed capacity.

Required /Participant's Date of Hire \_\_\_\_\_ Required / Employer EIN Federal Tax ID # \_\_\_\_\_

Work Site (Name) \_\_\_\_\_

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer's Stamp

**SECTION III: MATCH SITE FACILITIES** (Complete only if match required.) Affix employer's stamp/seal below or employer verification on letterhead, in addition to this form. - REQUIRED

This section is to be completed only by a representative of the employer, who is authorized to financially bind the employing facility to the commitment. If the facility is a Florida Licensed hospital (other than teaching hospital or specialty hospital for children), birth center or nursing home, you must agree to contribute up to \$2,000 per year, per program participant, for a maximum of four years. The match payment must be received by the Florida Department of Education, NSLFP before a payment will be made on behalf of the program participant.

*I fully understand, accept and agree to the conditions of my facility's contribution to the NSLFP. I understand I will be notified by the participant when the Match Payment is due from this facility. Within 30 days of receipt of notification, this facility will remit up to \$2,000 on behalf of the program participant, each year of eligible participation, for a maximum of four years.*

Required /Participant's Date of Hire \_\_\_\_\_ Required / Employer EIN Federal Tax ID # \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Facility \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer's Stamp



**NURSING STUDENT LOAN FORGIVENESS PROGRAM (NSLFP)  
LOAN PRINCIPAL CERTIFICATION**

Notice: Section 837.06, Florida Statutes, False official statements.—Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083

**SECTION I: To be completed by the applicant**

(Only principal loan balances submitted with NSLFP Initial Application will be considered.)

This form must be submitted to your lender. Allow adequate time for the lender(s) to comply with this request and return the form(s) to you. **If you have more than one lender, a Loan Principal Certification Form must be mailed to each lender.** If the loan(s) has/have been sold to another lender or the loans are consolidated, submit this form to the current holder of the loan(s), not the original lender.

1. **Applicant's Name** \_\_\_\_\_
2. **Social Security Number** \_\_\_\_\_
3. **Address** \_\_\_\_\_  
Street City State Zip Code
4. **Home Telephone Number** (\_\_\_\_) \_\_\_\_\_

**Dear Lender** I have applied for enrollment in the Florida Department of Education's NSLFP. The program assists nurses with payment of student loans incurred toward a nursing education. I hereby authorize you to release any information requested by the Florida Department of Education, NSLFP, regarding my loan(s). The Florida Department of Education will disburse any payments I receive directly to you. This payment must be applied to the outstanding principal balance only.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**SECTION II: Lender Loan Certification-  
To be completed by lender**

This completed form **must** be returned to the applicant identified above.

1. **Current PRINCIPAL Balance \$** \_\_\_\_\_ **Valid through** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y
2. **Name of Lending Institution** \_\_\_\_\_ **Federal ID Number** \_\_\_\_\_
3. **Payment Address** \_\_\_\_\_  
Street or PO Box City State Zip Code

By signing below, I certify that this borrower is **not currently** in default status regarding the referenced loan(s).

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name and Title (Print)** \_\_\_\_\_ **Phone Number** (\_\_\_\_) \_\_\_\_\_

**Affix lender's stamp in box below or lender verification on letterhead, in addition to this form. - REQUIRED**

**Lender's Stamp**

## APPLICATION PACKET CHECKLIST

**Complete the following for submission:**

- ☐ NSLFP Initial Application
- ☐ Employment Verification Form
- ☐ Loan Principal Certification Form
- ☐ Legible copy of degree(s)/diploma(s)
- ☐ Legible copy of current nursing license

**The NURSING STUDENT LOAN FORGIVENESS PROGRAM Initial Application and required documents must be received by the Office of Student Financial Assistance by the deadline specified on page 3. Please mail to the following address:**

Florida Department of Education  
Office of Student Financial Assistance  
325 West Gaines Street, Suite 1340  
Tallahassee, Florida 32399-0400

**Special Note:**

- **Incomplete applications will not be considered for enrollment.**
- **It is recommended that you mail your application using a trackable mailing service.**