

Site Information

Solicitation of Interest #20283

Nurses Across New York Loan Repayment Program – Cycle I

Instructions: Complete all sections of this form for the second or other subsequent facility(s). Complete a separate form for each additional site. You will upload the completed pages together as Attachment 10 of the application.

1. Site # _____ of _____

2. Facility Name:

3. Facility Address:

4. County Where Facility is Located: _____

5. Region where facility is located (circle one): NYC Rest of State

6. Type of Facility (check one)

- _____ Federally Qualified Health Center,
- _____ Healthcare Agencies
- _____ Adult Care Facilities
- _____ Private Practice
- _____ Hospital
- _____ Nursing Home
- _____ Other: _____

7. Primary Facility New York State DOH, OASAS, or OHM Operating Certificate # or Department of State Identification #. This number can be obtained from your employers Administrative Office.

8. Percent of time spent at this Facility: _____ %

9. Is the Facility in a HPSA (circle one): Yes No

10. If yes, provide the HPSA number: _____