LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
OFFICE OF ADMINISTRATIVE OPERATIONS

Mental Health Psychiatrist Student Loan Repayment Incentive

CLAIM FORM

Upon completion of one continuous year of service, please complete this form and submit to Office of Administrative Operations at MDIncentive@dmh.lacounty.gov

INCOMPLETE OR ILLEGIBLE CLAIM FORM WILL BE REJECTED

I request the Student Loan Repayment award payment of $_____

☐ Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐ Year 5

FULL NAME:	**SSN:**

PROGRAM:	**JOB TITLE:**	**EMPLOYEE NUMBER:**

WORK LOCATION:

HOME ADDRESS:

CITY:	**STATE:**	**ZIP:**

PHONE #:	**Business E-MAIL:**

Service Obligation Date: _____ From _____ To	**Comments:**

The following requirement documents are attached:

- ☐ Copy of current Driver's License to validate identification
- ☐ Current DMH Employment Performance Evaluation
- ☐ Current Student Loan Statements

_____ _____
Awardee's Signature Date

PRINT & SUBMIT

TO BE COMPLETED BY OFFICE OF ADMINISTRATIVE OPERATIONS _____

This claim is: ☐ Approved ☐ Denied

_____ _____ _____
Signature of Authorized Staff Print Name Date