MIHL – ECSI

Request for Service Deferment/Cancellation

(Family Medicine; Osteopathic Medicine; Optometry; General Dentistry; Podiatry; Prosthetics/Orthotics; Chiropractic Medicine; Veterinary Medicine; Physical, Speech, and Occupational Therapy; Psychology)

PART I – TO BE COMPLETED BY THE BORROWER (COMPLETE IN INK)

Personal Information:

Last Name	First Name	Last Four of SSN (XXXX)
Street Address	City	State
Zip	Date of Birth	Email Address
Home Phone #	Cell Phone #	Work Phone #

Request for Service Deferment:
A request for service deferment should be submitted at the **BEGINNING** of each year of required service.

Request for Service Cancellation:
A request for service cancellation should be submitted at the **END** of each year of required service.
Cancellation is granted for continuous 12-month employment periods.

Deferment Period BEGIN Date Current Work Year Start Date (MM/YYYY)	**Expected Deferment Period END Date** Current Work Year End Date (MM/YYYYY)
Cancellation Period BEGIN Date Completed Work Year End Date (MM/YYYY)	**Cancellation Period END Date** Completed Work Year End Date (MM/YYYY)

(Altered dates will not be accepted)

CERTIFICATION: This is to certify that I WAS and/or AM a FULL-TIME licensed Family Medicine doctor, Osteopathic Medicine doctor, Optometrist, General Dentist, Podiatrist, Prosthetics/Orthotics specialist, Chiropractor, Veterinarian, Physical/Occupational Therapist, or Psychologist practicing in a Board-approved discipline at:

Clinic/Hospital			Clinic/Hospital Street Address
City, State, Zip	Telephone #	County	Type of Service (board-approved options listed above)

I HEREBY CLAIM THAT THE ABOVE INFORMATION IS TRUE.

X _____
Borrower's Signature Date

Family Medicine Doctors Only Circle Practice Type:

Family Medicine Internal Medicine OB/GYN Pediatric

PART II – TO BE COMPLETED BY HUMAN RESOURCE DEPARTMENT

I CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT.

X _____
Signature of Authorizing Official Date

Printed Name, Title, and Address of Official	Official Stamp or Seal - If no stamp or seal is available please provide letterhead certification, signed by appropriate human resources official, in addition to this form. The letter must include employee's name, practice field and type, and full-time employment dates.
Telephone #	

Dates Borrower Employed Full-time (MM/DD/YYYY)	From:	To:
Dates Borrower Employed Part-time (MM/DD/YYYY)	From:	To:

NOTE: This form is INCOMPLETE without borrower's signature, social security number, beginning and ending dates of service deferment and/or cancellation period, and COMPLETE Part II certification.

RETURN FORM TO:
Mississippi Institutions of Higher Learning (MIHL)
C/O Heartland ECSI
P.O. Box 1289
Moon Township, PA 15108

CONTACT:
Email: webcservice@ecsi.net
Phone: 888.549.3274

PART III FOR OFFICE USE
PROCESSED BY: _____ DATE: _____