MIHL – ECSI **Request for Residency Deferment**

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 Residency Deferment:
A request for residency deferment should be submitted each year of the residency. Maximum length of residency:
General Dentistry – 1 year
Medicine (Family Medicine, Internal Medicine, or Pediatrics) – 3 years
Osteopathic Medicine and OB/GYN – 4 years
Optometry – 1 year
Podiatry – 3 years
Chiropractic Medicine – 1 year
Veterinary Medicine – 4 years

Deferment BEGIN Date Residency Start Date (MM/YYYY)	Expected Deferment END Date Residency End Date (MM/YYYY)

(Altered dates will not be accepted)

CERTIFICATION: This is to certify that **I AM or WILL BE** a **FULL-TIME** licensed health care professional completing a required residency in a Board-approved area for the above dates at:

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

I HEREBY CLAIM THAT THE ABOVE INFORMATION IS TRUE.

X _____
Borrower's Signature Date

PART II – TO BE COMPLETED BY RESIDENCY GRANTING INSTITUTION

I CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT.

X _____
Signature of Authorizing Official Date

Printed Name, Title, and Address of Official
Telephone #

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, residency field, and full-time residency dates.

NOTE: This form is INCOMPLETE without borrower's signature, social security number, beginning and ending dates of residency deferment request, and COMPLETE Part II certification. For residency deferment, students graduating with their degree MUST provide a copy of their appropriate Mississippi license.

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 ONLY
PROCESSED BY: _____ DATE: _____