

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

Name	Social Security #	ACS Account # (if available)
Street Address	City	State
Zip	Date of Birth	Email Address
Home Phone #	Cell Phone #	Work Phone #

**MEDICAL/DENTAL/PODIATRY/OPTOMETRY/
CHIROPRACTIC RESIDENCY DEFERMENT**

BEGINNING (mm/dd/yyyy)	ENDING (mm/dd/yyyy)
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(Altered dates will not be accepted)

THIS IS TO CERTIFY THAT I **WILL BE** A FULL-TIME LICENSED MEDICAL PHYSICIAN/GENERAL DENTIST/
PODIATRIST/OPTOMETRIST/CHIROPRACTOR COMPLETING A REQUIRED RESIDENCY FOR THE ABOVE DATES AT:

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

THIS FORM IS INVALID WITHOUT BORROWER’S SIGNATURE, SOCIAL SECURITY NUMBER, BEGINNING AND ENDING DATES, AND PART II CERTIFICATION. **PLEASE NOTE: FOR RESIDENCY DEFERMENT, STUDENTS GRADUATING WITH THEIR DEGREE MUST PROVIDE A COPY OF THEIR MISSISSIPPI MEDICAL/DENTAL/PODIATRIC LICENSE.**

I HEREBY CLAIM THAT THE ABOVE INFORMATION IS TRUE.

X _____ Date _____
Borrower’s Signature

PART II – TO BE COMPLETED BY HUMAN RESOURCE DEPARTMENT

I CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT.

X _____ Date _____
Signature of Authorizing Official

Printed Name, Title, and Address of Official	Official Stamp or Seal If no stamp or seal is available, please provide letterhead certification.
Telephone #	

RETURN FORM TO:
ACS, INC. – ATTN: LINDA
900 Commerce Drive, Ste. 320
Oak Brook, IL 60523
800.432.2372 ext 2788
FAX 630.203.2796

Maximum length of residency:
General Dentistry – 1 year
Podiatrist – 4 years
Medicine (Family Medicine, Internal Medicine, OB/GYN, or Pediatric) – 4 years
Optometry – 1 year
Osteopathic – 4 years
Chiropractic – 1 year

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