Student Loan Repayment Program Service Agreement

NAME *(Print or type first, middle, last)*	Social Security Number	Institute or Center	Date

In consideration of the student loan repayment benefit for which I qualify under 5 U.S.C. 5379 as implemented by the regulations of the U.S. Office of Personnel Management (5 CFR, Part 537), the policies of the Department of Health and Human Services, and the National Institutes of Health, I hereby agree:

1. To serve at the Department of Health and Human Services (HHS) for ☐ 3 years (initial contract) or ☐ 1 year extensions.

2. The amount of the student loan repayment benefit is $_____ (up to $10,000). I understand that the commitment to repay my loan is for one year, subject to yearly extensions.

3. If student loan repayment benefits are made in the 2nd or 3rd year, my service agreement will not be extended.

4. If student loan repayment benefits are made beyond 3 years, my service agreement will be extended by one year for each payment made beyond the 3rd year.

5. The service agreement is effective _____ *(month/day/year)* through _____ *(month/day/year).*

6. This service agreement in no way constitutes a right, promise, or entitlement for continued employment or noncompetitive conversion to the competitive service. Acceptance of this agreement does not alter the conditions or terms of my employment; accordingly, this agreement will not preclude nor limit the Agency from effecting personnel actions as may be appropriate.

7. That in the event I voluntarily leave HHS, or in the event that I am involuntarily separated for misconduct or performance before completing the agreed upon period of service, I will be indebted to the Federal Government and must reimburse HHS for the full amount of any student loan repayment benefits received under this service agreement.

8. I am responsible for making loan payments on the portion of the loan that continues to be my responsibility.

9. The student loan repayment benefits made do not exempt me from my responsibility and/or liability for the loan.

10. I am responsible for any income tax obligation resulting from the student loan repayment benefit.

11. HHS/NIH is not responsible for any late fees assessed by the lender if the student loan repayment benefit is not received on time.

12. The student loan repayment benefits made on my behalf from the Federal Government will not exceed $10,000 per calendar year or the lifetime maximum amount of $60,000.

13. Other condition(s) agreed to by employee and the NIH:

I AGREE TO THE TERMS OF THIS SERVICE AGREEMENT:

Signature	Name *(print/type)*	Date

Privacy Act Notification Statement

Collection of this information is authorized under 5 U.S.C. 5379. The purpose of collecting the information is to establish terms under which an individual receives a student loan repayment benefit under the Student Loan Repayment Program. The information will be used as a basis for payroll actions. This information may be disclosed to the Internal Revenue Service for tax withholding purposes, the Department of Treasury for payroll action, the Department of Labor for worker compensation claims and the Department of Justice for other lawful purposes including law enforcement and in the event of litigation. In addition, this information may be used within DHHS for study purposes, such as projection of staffing needs, and/or creation of non-identifiable statistical data for reports to other Federal agencies and Congress. The request for this information is voluntary, however, if information is not provided it could preclude the processing of the student loan repayment benefits request. *Statement is pursuant to the Privacy Act of 1974 (P.L. 93-597)*

Authority for Collection of Information: 5 U.S.C 5379.

Purpose and Uses

The main purpose for collecting the information requested on the above mentioned form is to establish the terms under which an individual receives a student loan repayment benefit under the Student Loan Repayment Program. The information collected will be used as a basis for payroll actions. Accordingly, disclosure of identifiable information, including your Social Security Number (SSN), may be made to the Internal Revenue Service for tax withholding purposes, the Department of Treasury for payroll action, and to the Department of Labor for worker compensation claims. This information may also be disclosed to the Department of Justice for other lawful purposes including law enforcement and in the event of litigation. In addition, these records, or information therefore, may also be used within DHHS for study purposes, such as projection of staffing needs, and/or creation of non-identifiable statistical data for reports to other Federal agencies and Congress.

Information Regarding Disclosure of Your Social Security Account Number

Disclosure of the SSN is mandatory since it is the identifier used by the Internal Revenue Service and for the withholding of taxes from your salary. The use of the SSN is made necessary because of the large number of present and former employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN. It is used primarily to identify an employee's personnel, leave, and pay records and to relate on to the other. In this regard, it is also used by the HHS to locate records in order to respond to lawful requests for information from former employers, educational institutes, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters.

Effect of Non-disclosure

Your submission of this agreement is voluntary; however, if the agreement is submitted, omission of significant information requested would preclude continued processing of the agreement for you to receive an allowance because payroll would be unable to process the necessary actions.

Human Resources Review		
Signature *(CSD Branch Chief)*	Name *(print/type)*	Date