SUNY DOWNSTATE Medical Center

HEALTH SCIENCE CENTER AT BROOKLYN FOUNDATION, INC.

450 Clarkson Avenue, Box 1219, Brooklyn, NY 11203 718-270-3148/4399

DR. WILLIAM AND VIRGINIA WAX STUDENT LOAN - PROMISSORY NOTE

Name (Last, first, middle initial): _____ Date of Birth: _____

Social Security Number: _____ Email: _____

Phone Number: _____ Cell Phone Number: _____

Permanent Address (street, city, state, zip code):

_____

_____

Parents' Full Name: _____

Parents' Permanent Address (street, city, state, zip code):

_____

_____

Driver's License Number (List state abbreviation first): _____

Wax Loan Amount: $_____

TERMS AND CONDITIONS

I am obligated to repay this no-interest loan to the Health Science Center at Brooklyn Foundation, Inc. (HSCBF) in ten equal annual payments, with the first payment due on April 1st after completion of residency training. Annual payments may be made quarterly (April 1, July 1, October 1 and January 1) or in one lump sum on April 1st. If I leave school for any reason, I must start payments on the 1st of the month immediately following my absence. If I return to classes after a leave of absence, my payments will cease until after I graduate. If I do not make a scheduled payment within 30 days of its due date, I will be charged a late fee of $50 for each month payment is not made. If I do not make payment by the anniversary of the due date, the entire outstanding balance will be turned over to a collection agency and my transcript may be withheld. I will inform the HSCBF Business Office in writing of any change in my name, address, telephone number, email, driver's license, Clinical Residency Training or enrollment status.

I promise to re-pay the HSCBF the sum of $_____advanced to me for the loan period _____ under the terms of this Note, plus other fees which may become due as provided in this Note. I promise to pay all reasonable collection costs, including attorney fees and other charges, necessary for the collection of any amount not paid when due. I will not sign this Note before reading it. In the event of my death, the school will cancel the total amount owed on this loan. If I become permanently and totally disabled after I received this loan, the school will cancel the total amount owed on this loan. This loan has been made to me without security or endorsement. My signature certifies that I have read, understand, and agree to the terms and conditions of this Promissory Note.

THIS IS A LOAN THAT MUST BE REPAID. I understand that I will reaffirm my obligation periodically throughout the term of said loan and that refusal to do so will cause the remaining balance to become immediately due and payable.

_____ _____

Borrower's Signature Date

State of New York: County of _____

On this day of , 20 , before me personally , to be known and to me the person came

____ _____ ___ _____

described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

_____

Notary Public

HEALTH SCIENCE CENTER AT BROOKLYN FOUNDATION, INC.
450 Clarkson Avenue, Box 1219, Brooklyn, NY 11203 718-270-3148/4399

DR. WILLIAM AND VIRGINIA WAX STUDENT LOAN STATEMENT OF RIGHTS AND RESPONSIBILITIES

Borrower Name (Last, First): _____ Social Security #: _____

This loan has been made possible by the generosity of Dr. William and Virginia Wax, an alumnus of Downstate Medical Center, in order to assist in making medical education achievable and affordable. You have a moral and legal obligation to repay this loan, and these repayments will go to fund additional loans to medical students in the future. A Student Loan is a serious legal obligation. Therefore, it is extremely important that you understand your rights and responsibilities. When you, the student borrower, sign this statement, it means that you understand your responsibilities and you agree to honor and be legally bound by them.

1) I understand that I must, without exception, notify in writing the Health Science Center at Brooklyn Foundation Inc. (HSCBF) Business Office, Box 1219, 450 Clarkson Avenue, Brooklyn, NY 11203 of any changes in the following personal information: address, telephone number, parent's address, driver's license number , name changes, and/or clinical residency training status.
2) I understand that my first annual payment will be due on April 1st after completion of clinical residency training.
3) I understand that if I leave school for any reason, my loan balance will become immediately due and payable. I will contact the HSCBF Business Office at 718-270-3148/4399 to arrange a repayment schedule.
4) I understand that if I return to classes after a leave of absence, my payments will cease until April 1st after completion of my clinical residency.
5) I understand that my annual payment will be one tenth of the total amount loaned, and that annual payments may be made quarterly (April 1, July 1, October 1 and January 1) or in one lump sum on April 1st.
6) I understand that there will be no interest due on this loan.
7) I understand that if I miss a scheduled repayment, the total loan will become immediately due and payable as stipulated in the Promissory Note, and legal action will be commenced to recover the monies due to HSCBF. My credit rating would be affected, and my transcript may be withheld.
8) I understand that if a payment is not received within 30 days of its due date, a late fee of $50 will be assessed for each month payment is not received. Written communication must be made with the HSCBF Business Office as to why the payment was delayed and payment terms must be provided to avoid having the remaining balance declared immediately due and payable and legal action commenced.
9) I understand that I must promptly answer any communication received by me from the HSCBF, or its designees, concerning my loan. I understand that I must reaffirm my obligation to the HSCBF in writing, as well as the authorization to third parties to release my personal information specified above, periodically until the note is completely satisfied. If I don't reaffirm the loan balance as requested within 30 days of the request, I understand that requests for transcripts will be denied, and my loan will become immediately due and payable.
10) I authorize the HSCBF to obtain information concerning my student status, my year of study, my dates of attendance, graduation, withdrawal, transfer, clinical residency status, current address, current telephone (Authorization form to release this information from third parties to the HSCBF is attached).
11) In the event of default I authorize the HSCBF to report this loan to credit reporting bureaus.

Total amount of credit provided to you through Wax Loans is: $_____.

_____

Signature of Borrower Date Student Number Date of Birth

_____

Permanent Address

_____

Telephone Number Cell Phone Number E-Mail

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DR. WILLIAM AND VIRGINIA WAX STUDENT LOAN
EXIT LOAN REPAYMENT AGREEMENT

Students who have borrowed funds through the Health Science Center at Brooklyn Foundation, Inc. (HSCBF) must complete this form (please print). You are entitled to a copy of your signed promissory note from the HSCBF, upon your request. The HSCBF is responsible for servicing and collecting loans granted by the Dr. William and Virginia Wax Student Loan Fund. Payments, questions, name and address changes, and requests for deferment applications or alternative repayment plans should be directed to:

HSCBF Business Office
718-270-3148/4399

_____ Male ☐ Female ☐ Date of Birth _____
Last Name First Name Middle Init.

_____
Formerly Known As (print above)

_____
Permanent Home Address (print above)

_____
City State Zip Code

Telephone No: ( )_____

Cell Phone No: ( )_____

Spouse's Name_____

E-Mail _____

Office Use Only

Date of First Advance: _____

Date of Last Advance: _____

This borrower will cease (or has ceased) attendance at SUNY Downstate Medical Center Campus as of
Separation Date:
_____

Residency Completion Expected Date:
_____

REPAYMENT AGREEMENT

I understand that my outstanding Dr. William and Virginia Wax Student Loan balance must be repaid, as stated in my promissory note, within a ten-year period beginning April 1st after the completion of my residency training. If I leave school for any reason prior to completion of my program, my loan balance will become immediately due and payable. I will contact the HSCBF Business Office at 718-270-3148/4399 to arrange a repayment schedule. I understand and agree to all of the rights & responsibilities as set forth in the statement on the reverse side of this form.

Total loaned on Master Promissory Note: $_____

Net Total Loaned:	Interest Rate:	Yearly Payment: Amount:	Grace Period Ends:	1st Payment Due Date:	Number of Pmts:	Total Interest:
$_____	0 %	$_____	_____	_____	_____	$0.00

AFTER RESIDENCY

I have read, understand and agree to all terms disclosed on both the front and reverse side of this repayment agreement.

Signature of Borrower: _____ Date: _____

HEALTH SCIENCE CENTER AT BROOKLYN FOUNDATION, INC.
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Signature of Campus Personnel: _____ Date: _____

DR. WILLIAM AND VIRGINIA WAX STUDENT LOAN