DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

Read Privacy Act Statement on back of page 2 before completing this agreement

AGREEMENT

To Receive An Allowance Under the Federal Physicians Comparability Allowance Program (5 U.S.C. 5948)

NAME *(Print or Type)*	AGENCY

In consideration of payments of the allowance for which I qualify under the Federal Physicians Comparability Allowance (PCA) Program (5 U.S.C. 5948) as implemented by the Regulations of the Office of Personnel Management (5 CFR Part 595), the policies of the Department of Health and Human Services, and the Public Health Service, I hereby agree:

To serve in _____ (agency), PHS for ☐ one ☐ two years in a position(s) designated as Category _____ Subcategory _____ Tier _____.

That the amount of allowance payable to me shall be determined by the Assistant Secretary for Health or his designee as prescribed by the HHS plan for payment of such allowances. The allowance payable under this agreement is $_____ per year for _____ year(s).

That if I elect to enter into a two-year contract, the Assistant Secretary for Health or his designee may limit this agreement to one year if it has been determined that the category or subcategory to which I am assigned will not have recruitment or retention problems after the one year period.

That acceptance of this agreement does not alter the conditions or terms of my employment.

That my entitlement of this allowance is based solely on the position to which I am assigned and is not associated with my performance and/or conduct. Accordingly, this agreement will not preclude nor limit the Public Health Service's right to take corrective or disciplinary actions as may be appropriate.

(a) That in the event I voluntarily or because of misconduct fail to complete at least one year of service in a position which entitles me to receive the allowance, I will refund the amount of the allowance I have received unless the Assistant Secretary for Health, in accordance with prescribed regulations, determines that my failure to complete my agreed period of service is due to circumstances which are beyond my control.

(b) That in the event I voluntarily or because of misconduct fail to complete the second year of a two-year agreement in a position which entitles me to receive the allowance, I will refund the amount of the allowance I received under this agreement for the 26 weeks of service immediately preceding the termination unless the Assistant Secretary for Health determines that my failure to complete my agreed period of service is due to circumstances which are beyond my control.

(c) It is further agreed that any amount which I am obligated to refund under (a) or (b) of this paragraph will be a debt due to the United States which I hereby agree to pay in full as directed by the Department of Health and Human Services.

That the effective date of this agreement and payments pursuant to this agreement will normally commence on the first day of the pay period after the following conditions are met:

(a) My position of record is approved by the Assistant Secretary for Health as one of a category or subcategory for which recruitment and retention problems exist; and

(b) The agreement is signed and notarized.
In unusual circumstances, such payments will commence on a later date specified by me or a date specified by the agency which is _____.

That my entitlement to the allowance under this agreement will terminate when any of the following occur:

(a) Cessation of employment with the Public Health Service.

(b) Assignment to a position excluded from PCA coverage or not approved for PCA.

(c) Completion of agreed period of service or enactment of superseding law.

(d) Change of tour of duty to less than half-time.

(e) October 1, 1990 or any subsequent date established by law.

(This section is appliacable only to individuals who have served in a health professionals shortage area and have signed a contract with the Federal Government to serve in such an area in return for Government paying all or part of a student loan.)

That the amount equivalent to any loan repaid under a Federally supported loan repayment program will reduce the allowance for which I would otherwise be eligible under applicable regulations and instructions. That failure to report a repayment contract now in effect or which becomes effective during the period of this agreement will result in my obligation to refund the amount of allowance I have received. I am ☐ am not ☐ participating in a Federally supported loan repayment program. The amount that has or will be repaid by this loan repayment agreement is:

$ _____ for the period _____ to _____ .

That the regulations and policies implementing 5 U.S.C. 5948 are incorporated into and made a part of this agreement and I have read these regulations and policies.

I am board certified in the following medical specialty or specialties:

Specialty — Date of Certification

I AGREE TO THE TERMS OF THIS CONTRACT

SIGNATURE	Print/Type Name	Social Security Number	Date

NOTARIZATION

Subscribed and sworn before me this _____ day of _____ A.D. _____ at _____ (City and State) _____ Zip Code

SIGNATURE OF NOTARY	Date Commission Expires

EMPLOYMENT DATA, ALLOWANCE APPROVAL DATA, COMPUTATION OF ALLOWANCE AND APPROVAL OF AGREEMENT

(To be approved by the Authorized Management Official and Certified by the Servicing Personnel Office)

NAME *(Print or Type)*	TITLE, SERIES AND GRADE
POSITION NO.	ORGANIZATION *(Bureau, Center, Agency)*

Location

TYPE OF APPOINTMENT

Permanent	Term
Temporary	Not to Exceed

OFFICIAL TOUR OF DUTY

Full Time	Part Time
Regularly scheduled hours per pay period	

Assignment requires board certification

☐ Yes ☐ No

The Assistant Secretary for Health has determined that this position is one in which recruitment and retention problems exist.

Notice of this determination was given in approval certificate # _____ dated _____.

This position was approved for PCA coverage under Category _____ Subcategory _____ Tier _____.

Physician has served as Government physician for

☐ 24 months or less ☐ more than 24 months.

(Experience as a Medical Officer in the PHS Commissioned Corps or in the Veterans Administration paid under Chapter 73 of 38 U.S.C. is also creditable.)

Amount to be paid under this agreement is $ _____ per year for _____ year(s) based on _____ hours per pay period.

This amount is determined as follows:

Approved allowance for category *(for category I & II, show amount for shortage specialty, if approved)*	$ _____
Allowance for duties and locale, if approved	_____
Allowance for board certification, if approved	_____
Retention allowance *(for two-year contracts only)*	_____
TOTAL	$ _____
TOTAL AMOUNT PAYABLE	$

* Note limitations of $14,000 per annum for physicians who have served as Government physicians for 24 months or less or $20,000 for physicians with more than 24 months' service as Government physicians. Also note limitation of $10,000 for individuals with less than two years' service who execute one-year agreement and $16,000 limitation for individuals with two or more years' service signing one-year agreement.

This agreement is effective on _____ and expires on _____

(All contracts must begin on the first day of a pay period and end on the last day of a pay period.)

I CERTIFY THAT THIS POSITION REQUIRES A PHYSICIAN AND APPROVE THIS AGREEMENT

Authorized Management Official Date

I CERTIFY THAT THIS POSITION IS ONE THAT THE ASSISTANT SECRETARY FOR HEALTH HAS APPROVED FOR PCA PAYMENT AND THAT THE DATA IS ACCURATE:

Personnel Official Date

for initiating actions to recover such refunds in accordance with procedures in HHS Instruction 595-1, dated March 10, 1987 and updated April 25, 1988.
5 CFR 595.106 requires that physicians who terminate their contracts before the expiration date refund all or a portion of the allowance received. Servicing Personnel Officers are responsible

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