# EXHIBIT A

## LCMC HEALTH – CHAMBERLAIN UNIVERSITY
## CALLED-TO-CARE SCHOLARS PROGRAM

### RECIPIENT DISCLOSURE STATEMENT

| | |
|---|---|
| **Recipient Name:** _____<br><br>**Recipient Address:** _____<br><br>**Recipient Identification Number:** _____ | **Underwriter and Source of Funds:** Louisiana Children's Medical Center d/b/a LCMC Health<br><br>**Underwriter Address:** 200 Henry Clay Ave., New Orleans, LA 70118 |
| **University:** Chamberlain University – Metropolitan New Orleans | |

**Important Information:** The LCMC Health Called-to-Care Scholars Program / Program Description and Recipient Agreement (the "Agreement") contains information about the Program including eligibility, program requirements, nonpayment, default, any required repayment, and the possibility and consequences of the forgiveness of the Liquidated Damages. All capital terms used herein shall have the meaning set forth in the Agreement.

**Anticipated Disbursement Date**: First Disbursement _____, 202___ and each session thereafter until the earlier of: (i) 38 months; (ii) graduation; (iii) an Event of Default.

| **Tuition Payment Per Session** | **Maximum Tuition Payment** | **Interest** |
|---|---|---|
| The maximum Tuition payments made to University on your behalf per session: **$ 3,000.00** | The maximum amount of Tuition payments made to University on your behalf: **$54,000.00** | Greater of:<br>(a) **1.50%**, or<br>(b) **Short-term AFR** |

**My Financial Obligation:** shall be equal to the total Tuition payments made by LCMC Health to University on my behalf, which shall bear interest at a rate, compounded semiannually, equal to the greater of (a) 1.50%, or (b) the then-current short-term applicable federal rate at the time of a Tuition payment. My Financial Obligation, including interest, will be forgiven as I fulfill the Work Commitment.

**Tax Implications:** The amount of the Financial Obligation forgiven will be included on the Recipient's Form W-2 for the year in which the Financial Obligation is forgiven in accordance with applicable law. Recipient should consult his or her tax advisor regarding tax implications arising from participation in the Program.

**Effect of Default:** Upon an Event of Default, the unforgiven/unpaid portion of my Financial Obligation shall be considered Liquidated Damages, shall be due and payable within twelve (12) months. Thereafter, the unforgiven/unpaid portion will carry a default interest rate of five percent (5%), compounded monthly.

**Prepayment:** If I pay off the Liquidated Damages early, I will not have to pay a penalty.

**Cancellation:** Recipient may cancel their participation in the Program and associated eligibility for Tuition payments, without penalty, until midnight of the third (3rd) business day following receipt of the Agreement and this Disclosure Statement. Cancellation must occur in writing by _____, 202__ and shall be sent to _____LCMCHealthScholarsNotices@chamberlain.edu _

*Recipient's signature below indicates that Recipient has received the Agreement and that Recipient understands his/her obligations and agrees to the terms of the Agreement.*

*Recipient hereby authorizes University and/or LCMC Health to record on the grid on page 2 of this Disclosure Statement all Tuition payments made by LCMC Health on Recipient's behalf and the total Financial Obligation, the corresponding Work Commitment of Recipient, and any forgiveness and/or prepayment thereof; however, the failure to make any such notation shall not affect the rights of LCMC Health or any obligations of Recipient, hereunder or under the Agreement.*

Signature of Recipient: _____ Date: _____

Printed Name: _____

## EXHIBIT A

| SESSION | TUITION PAID ON BEHALF OF RECIPIENT | TOTAL TUITION PAYMENTS | TOTAL INTEREST | TOTAL FINANCIAL OBLIGATION | TOTAL WORK COMMITMENT |
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