O.M.B.: 0915-0140
Expiration Date:

Public Burden Statement

6-MONTH VERIFICATION OF EMPLOYMENT FOR PARTICIPANTS IN THE NURSING EDUCATION LOAN REPAYMENT PROGRAM (NELRP)

TO BE COMPLETED BY THE AUTHORIZED PERSONNEL OFFICIAL OF THE FACILITY

Applicant's Name (your employee): _____

Applicant's Social Security Number: _____

Name of Health Care Facility: _____

Address of Health Care Facility: _____

Please note: Under the NELRP, participants must be **registered nurses** providing full-time nursing services at a critical shortage facility. Full-time nursing service is defined as the provision of nursing services for a minimum of 32 hours per week. No more than 7 weeks per service year can be spent away from the facility for vacation, holidays, continuing education, illness, or any other reason. Individuals who have an existing service obligation are not eligible to participate in the NELRP. RN's working PRN or as Pool Nurses, or for Travel or Nurse Staffing Agencies are not eligible for the program.

I hereby certify that, during the period from _____ through _____, (or through his/her last day worked as specified below), the individual identified above:

1. Was employed by the facility identified above in:

( ) a full-time capacity (defined as a registered nurse providing nursing services for a minimum of 32 hours per week),
(a) ( ) the entire period, or
(b) ( ) part of the period from _____through_____; and/or
MM/DD/YYYY **MM/DD/YYYY**

( ) a less than full-time capacity (defined as a registered nurse providing nursing services for less than 32 hours per week) for
(a) ( ) the entire period, or
(b) ( ) part of the period from _____through_____;
MM/DD/YYYY **MM/DD/YYYY**

2. Is licensed to practice as a registered nurse without restrictions. Please provide the following information:
License Number: _____ State: _____ Expiration Date:_____;

3. Did not work the following number of hours due to vacation, holidays, continuing education, illness, maternity, or any other reason: _____;

4. Is required to work the following number of hours per week _____, or bi-weekly_____;

5. (if applicable) terminated employment on _____(last day worked); and
MM/DD/YYYY

6. Works at the following type of facility: (a) private nonprofit _____
(b) private for profit _____
(c) public / government owned _____

_____
Name of Authorized Personnel Official (Please Print) Title

_____
Signature of Personnel Official Date

_____ _____
Personnel Office Telephone Number Personnel Office Fax Number