

Public Burden Statement

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**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