Form Approved
OMB No. 0915-0301
Expires 07/31/2009

Nursing Scholarship Program
Employment Certification Form

PART I: TO BE COMPLETED BY SCHOLARSHIP RECIPIENT

Name: ____
Address: ____
City, state, zip: ____________________________________
Phone: ____
Email address: ______________________________________

Place of Employment: _________________________________
Employment Address: _________________________________
City, state, Zip: _____________________________________
Your position/title: ___________________________________
Date of employment as a Registered Nurse began in this job on:
____
Hours per week of clinical practice: _________________________

Type of health care facility (check one):
___ Hospital
___ Indian Health Service Health Center
___ Native Hawaiian Health Center
___ Federally Qualified Health Center
___ Rural Health Clinic
___ Nursing Home
___ Home Health Agency
___ Hospice Program
___ State or Local Public Health Department
___ Skilled Nursing Facility
___ Ambulatory Surgical Center

I certify that I am employed as a Registered Nurse in the facility identified above and all the information is correct to the best of my knowledge. If I have a change in employment status, I will notify the Nursing Scholarship Program within 30 days.

Signature: ____________________________ Date: ___________

CONTINUE ON OTHER SIDE ►►►►►►►►►

PART II: *TO BE COMPLETED BY EMPLOYER*

I certify that the information concerning employment of the person listed as a Registered Nurse is correct.

Name of certifying official: ______________________________
Title: ____
Phone number: ____
Email address: _______________________________________

Has Employee Been Absent (e.g., on vacation, holidays, maternity leave, sick leave, etc.) for more than 7 weeks (28 work days) this year?

YES _____ NO _____ (If yes, please explain)

Signature: ____________________________ Date: ___________

After the form is completed, please mail to:

Nursing Scholarship Program
Division of Scholar and Clinician Support, BCRS
5600 Fishers Lane, Room 8A-19
Rockville, MD 20857
Fax: 301-451-5384

FOR NURSING SCHOLARSHIP PROGRAM OFFICE USE ONLY:

Health Care Facility Verification
___ Approved
___ Disapproved

Name of Program Official: ________________________________
Title: ____
Signature: ____________________________ Date: ___________