OMB Number: 2900-0000
Estimated Burden: 10 minutes

Health Professional Scholarship Program (HPSP) &
Visual Impairment and Orientation and Mobility Professionals Scholarship Program (VIOMPSP)

Annual VA Employment or Deferment Verification

HPSP/VIOMPSP: Department of Veterans Affairs, 1250 Poydras St., Suite 1000, New Orleans, LA 70113

PRIVACY ACT NOTICE

The VA is asking you to provide the information on this form under the authority of 38 U.S.C. 7502 and 7602 in order for VA to administer your scholarship award. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information for: civil or criminal law enforcement; congressional communications; the collection of money owed to the United States; litigation in which the United States is a party or has interest; the administration of VA training and scholarship programs, including verification of your eligibility to participate; and personnel administration. You do not have to provide this information to VA but, if you do not, VA may be unable to continue your scholarship award. If you give VA your social security number, VA will use it to obtain information relevant to administering your scholarship award. It also may be used for other purposes authorized or required by law.

☐ HPSP ☐ VIOMPSP	Participant's Name *(Last, First, MI)*:	Social Security Number:
Address *(Include Street Address, City, State, and ZIP Code)*:		Phone Number:
		Email Address:
Clinical Program while in school:		Date Degree Conferred:

☐ **Submitted for Annual Employment Verification**	☐ **Submitted for Annual Deferment Verification**
Attach a copy of your most recent Notification of Personnel Action (SF-50) to this report.	**Note:** Submit "Education Program Completion Notice/Service Obligation Placement" if the advanced education will be completed within 90 days.
Service Obligation Start Date:	Start date of the Advanced Clinical Education Program: ______
My Current Position Title:	Anticipated Date to begin Service Obligation: ______
Grade and Step:	What year in the Advanced Clinical Education has been Completed: ____ / Total Number of Years in the Program: ____
Name of VA Facility:	Name of Advanced Clinical Program:
Address of Facility *(Include Street Address, City, State, and ZIP Code)*:	Address of Program *(Include Street Address, City, State, and ZIP Code)*:
Note: Please check all applicable blocks below. If any of the blocks are not applicable, please explain in the comments section.	**Note:** Please check all applicable blocks below. If any of the blocks are not applicable, please explain in the comments section.
☐ I have continued full-time employment throughout my service obligation.	☐ I have continued in my Advanced Clinical Education Program.
☐ I have not been on leave without pay during my service obligation.	☐ I have received a satisfactory performance evaluation/review.
☐ I do not anticipate any changes to my employment status during my service obligation. If there is a change, I will notify the Scholarship Program Office as soon as I become aware of anticipated changes.	☐ I do not anticipate any changes to my educational status during my deferment. If there is a change, I will notify the Scholarship Program Office as soon as I become aware of anticipated changes.
☐ I have received a satisfactory performance evaluation.	

Comments:

Scholarship Participant's Signature ____________ Date ____________

Supervisor/Advisor Signature ____________ Date ____________

Supervisor/Advisor Title/Position ____________ Phone ____________