National Health Service Corps
Loan Repayment Program

U.S. Department of Health and Human Services
Health Resources and Services Administration

EMPLOYMENT VERIFICATION AND COMMUNITY SITE INFORMATION FORM

TO BE COMPLETED BY THE AUTHORIZED PERSONNEL OFFICIAL OF THE FACILITY ONLY

Concerning Applicants for the National Health Service Corps (NHSC) Loan Repayment Program (LRP)

Name of Clinician Applicant: ____

Last 4 Digits of the Applicant's Social Security Number: XXX –XX - __________

Name and physical location/address of each parent and/or any satellite site(s) where the applicant is working. Do not list the site(s) where the applicant is performing <u>support activities</u> for the approved NHSC site(s) (i.e., a hospital where he/she has privileges, a nursing home, a birthing center, a school, etc.). Submit a separate form for each <u>parent</u> company.

<u>Site 1</u> ____
____
____

No. of hours per week at site: ________

Admin Use Only:
HPSA Score ________
HPSA ID ____________________ UDS # ____________________
Approved R&R ☐ Yes ☐ No Exp Date ___________
NHSC Approved Vacancy ☐ Yes ☐ No Discp ____________

<u>Site 2</u> ____
____
____

No. of hours per week at site: ________

Admin Use Only:
HPSA Score ________
HPSA ID ____________________ UDS # ____________________
Approved R&R ☐ Yes ☐ No Exp Date ___________
NHSC Approved Vacancy ☐ Yes ☐ No Discp ____________

<u>Site 3</u> ____
____
____

No. of hours per week at site: ________

Admin Use Only:
HPSA Score ________
HPSA ID ____________________ UDS # ____________________
Approved R&R ☐ Yes ☐ No Exp Date ___________
NHSC Approved Vacancy ☐ Yes ☐ No Discp ____________

<u>Site 4</u> ____
____
____

No. of hours per week at site: ________

Admin Use Only:
HPSA Score ________
HPSA ID ____________________ UDS # ____________________
Approved R&R ☐ Yes ☐ No Exp Date ___________
NHSC Approved Vacancy ☐ Yes ☐ No Discp ____________

Please check/complete the below certifications applicable to the above site(s) and the above applicant.

☐ 1. I certify that the applicant identified above ***began or will begin working*** at the above-named site(s) on __________ ***(work start date)***.

☐ 2. I certify that the above applicant is engaged, or will be engaged on his/her work start date, in a full-time clinical practice, which means a minimum of 40 hours per week, 45 weeks per year as follows:

- **<u>For all health professionals, except as noted below</u>:** At least 32 hours of the minimum 40 hours per week are/will be spent providing direct outpatient care during normally scheduled clinic hours in the ambulatory care office(s) specified above. The remaining 8 hours per week is/will be spent providing clinical services to patients in the above offices, performing clinical support activities in alternate locations as directed by the above site(s), or performing practice-related administrative activities.
- **<u>For OB/GYNs, FPs practicing OB on a regular basis, providers of geriatric services, certified nurse midwives, pediatric dentists and behavioral and mental health providers</u>:** At least 21 of the minimum 40 hours per week are/will be spent providing direct outpatient care during normally scheduled clinic hours in the ambulatory care office(s) specified above. The remaining 19 hours per week is/will be spent providing clinical services to patients in the above offices, performing clinical support activities in alternate locations as directed by the above site(s), or performing practice-related administrative activities (with practice-related administrative activities not to exceed 8 hours per week).

☐ 3. I certify that the above applicant is engaged in ***less than the required full-time clinical capacity***, as defined above.

☐ 4. I certify that the above applicant was working full-time (as defined above) at the above site(s), but is on extended leave from ________________ to ___________________ due to ________________________________ ***(please indicate reason for extended leave - e.g., maternity, deployment, medical, etc.).***

☐ 5. I certify that the above applicant is **no longer working at the above site(s) or will be leaving the above site(s)**, and the last day of full-time work was or will be ___________________________.

☐ 6.* I certify that the above applicant is/will be an employee of the above site(s) and subject to the personnel system and employment policies of the above site(s).

☐ 7.* I certify that the above applicant will receive an income at least equal to what he or she would have received as Federal civil servant. (See http://opm.gov/oca/09tables/indexgs.asp and http://www.opm.gov/fedclass/html/gsseries.asp for information relating to Federal civil service salaries and job classifications for health professionals).

☐ 8.* I certify that the above site(s) provide the above applicant with malpractice insurance and tail coverage (either commercial or through the Federal Tort Claims Act).

* If the Executive Director does not check ALL 3 of the asterisked certifications (Items 6, 7 and 8), the above applicant will need to complete the Private Practice Option application on the NHSC website at http://nhsc.hrsa.gov/loanrepayment/ppo_app.pdf.

The certifications and information provided above are true, accurate and complete to the best of my knowledge and belief.

____ __________________________________

Executive Director Signature of Parent Company ***Print Name***

____

Name and Address of Parent Company

____ __________________________

E-mail Address ***Date Signed***

OMB No. 0915-0127 Expires 10/31/2010