



Nursing Education Loan Repayment Program

Fiscal Year 2011 Application Checklist & Supplemental Forms

To apply to the Nursing Education Loan Repayment Program, you must submit your online application at <https://nis.hrsa.gov> AND complete, print, and mail or fax these forms and the documentation listed in the Application Checklist.

Mail Completed Checklist and Forms to:
Nursing Education Loan Repayment Program (NELRP)
c/o HRSA Document Center
12530 Parklawn Drive, Suite 350
Rockville, Maryland 20852
OR
Fax: (301) 998-7377

For Questions, please call 1-800-221-9393 (TTY: 1-877-897-9910), Monday through Friday (except Federal holidays) 9:00am to 5:30 pm EST. **Email:** CallCenter@hrsa.gov

OMB No. 0915-0140 Expiration 01/31/2011

Public Burden Statement

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current OMB control number. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Office, 5600 Fishers Lane, Room 11A-33, Rockville, Maryland 20857.

NELRP APPLICATION CHECKLIST

Applicants must initial each item and sign and date the Checklist. **An application that is incomplete or inaccurate will not be processed.** You will not be contacted for additional information if your application is incomplete. Please make sure all forms are accurate and complete with signatures prior to submission of your application.

- _____ 1. **I certify that I have read the Application and Program Guidance (APG).**
- _____ 2. **Downloaded Supplemental Form and Supporting Documents.** These documents are to be completed prior to attempting to complete the online application cited below. Please note the information on your online application **must** match the information provided in the Supplemental Forms and Supporting Documents.
- _____ 3. **Loan Documentation.** The following documentation must be submitted for each loan for which the applicant is seeking repayment assistance under the NHSC LRP:
 - a. Loan Information and Verification Form (PDF) (for each lender or holder for the nursing education loan(s) for which applicants are seeking repayment assistance from NELRP)
 - b. Supporting document(s) from the lender/holder that provides all of the following information:
 - Loan Type
 - Original Loan Amount
 - Date Loan was Taken Out or Disbursed

For consolidated loans, the supporting document(s) must include all of the above required information for the consolidated loan and for each loan included in the consolidation.

- i. For federal educational loans, it is preferred that the above required information be obtained through a National Student Loan Data System (NSLDS) Aid Summary Report. You can access your report at <http://www.nslds.ed.gov>. You will need a PIN to log in to your secured area. If you do not have PIN, go to <http://www.pin.ed.gov>.
- ii. The following other types of official documents may include all or some of the above required information:
 - disbursement report
 - loan origination document
 - disclosure statement
 - detailed account statement
 - itemized list of loans included in a consolidation
 - promissory note

NOTE: You may need to submit more than one official document for each loan in order to provide all the above required information.

- c. Current Account Statement (no more than 30 days old), which includes the:
 - interest rate
 - current loan balance
- _____ 4. **NURSES: Employment Verification and Critical Shortage Facility Form (PDF).** To be completed by the authorized personnel official of the facility where the applicant is working to meet the service requirement for NELRP.

OR FOR NURSE FACULTY:

- _____ **NURSE FACULTY: Employment Verification Form** (PDF). To be completed by the authorized personnel official of the accredited school of nursing where the applicant is or will be (nurse faculty must be employed at the school of nursing no later than the application close date) working to meet the service requirement under the NELRP;
- _____ **AND**
- _____ **Certification of Accreditation Status for School of Nursing Educational Programs** (PDF). To be completed by the school of nursing's Dean's office or Program Chair to certify that the school's nursing education programs are accredited.
- _____ 5. **Authorization to Release Employment Information Form** (PDF). To be completed by the applicant. *I understand that if I become a NELRP participant, my employment status will be verified semiannually.*
- _____ 6. **Transcripts**. An applicant must submit transcript(s) (unofficial transcripts are acceptable) from each College, University, or School of Nursing attended for nursing education coursework directly related to the attainment of the nursing degree(s), if the applicant is seeking repayment for loans received while at that institution. Transcripts need to state what degree was granted and the year it was awarded, if applicable.
- _____ 7. **Authorization to Release Information** (PDF). To be completed by the applicant to authorize HHS' release of certain information.
- _____ 8. **Certification Regarding Debarment, Suspension, Disqualification and Related Matters**. To be completed by the applicant
- _____ 9. **NELRP Electronic Application** (<https://nis.hrsa.gov>). To be completed and submitted online by the applicant.
- _____ 10. **Completed NELRP Application Checklist & Instructions**.

Submit the following if applicable:

- _____ 11. **Documentation of your status as a U.S. Citizen**. U.S. National, or Lawful Permanent Resident (if applicable). This documentation is required only if you were born outside of the U.S. Examples include a copy of a certificate of citizenship or naturalization, U.S. Passport ID page, or Green Card.
- _____ 12. **Statement From Professional Group**. Advanced practice nurses employed by a professional group that practices at a Critical Shortage Facility must provide a written statement from the professional group indicating that the applicant will be working exclusively at one designated Critical Shortage Facility for at least 32 hours per week (for a minimum of 45 weeks per service year) for the 2-year duration of the applicant's NELRP contract, if the applicant receives an award.
- _____ 13. **Documentation that Perkins Loans are Not Eligible for Cancellation**. Applicants who have Perkins loans that are not eligible for cancellation must provide documentation a) from the school that the loans are not subject to cancellation under 34 CFR Part 674 or b) the current lender indicating that the Perkins loans were consolidated and paid in full.

I certify that the information submitted in all the supplemental forms and supporting documentation is true, accurate and complete to the best of my knowledge and belief and does not omit any materials facts. I understand that the information given may be investigated and that any knowing and willful false representation, or concealment, of a material fact is sufficient cause for rejection of this application, or, if awarded loan repayment, that I am liable for the return of all awarded funds and, further, that any such false statement or concealment may be punished as a felony under U.S. Code, Title 18, Section 1001, and subject me to civil penalties under the Program Fraud Civil Remedies Act of 1986.

Name (Please Print)

Signature

Date

Fax Completed Application Checklist and Forms Packages To: 301-998-7377



NURSING EDUCATION LOAN REPAYMENT PROGRAM
LOAN INFORMATION AND VERIFICATION FORM

APPLICANT: Complete one copy of this form for each lender or holder with which you have loans you wish to be considered for repayment under the NELRP. Your original loan date(s) must coincide with your school attendance dates for loans to be eligible for repayment. Please print clearly and complete all items to facilitate verification. If this form is incomplete or if any information is incorrect, the loan will be deemed ineligible.

1. Applicant's Name (Last, First, Middle) 2. Applicant's Social Security Number 3. Date of Birth
4. Complete Address 5. Phone
6a. Current Lending Institution 6b. Lender's Automated Access System Phone Number 7. Loan Account Number
8a. Lender's Address 8b. Address Where Payments are Sent (if different than Lender's Address)
9. Was the loan sold? Yes ___ No ___ (If you are not sure, check with your lender). If "yes" give the original loan holder's name and address.
9b. Is this a consolidated loan? Yes ___ No ___ (If you are not sure, check with your lender). If "yes" provide the original loan dates.
10. Original Date of this Loan 11. Original Amount of this Loan
12a. Current Balance (principal and interest as of (date) 12b. Interest Rate
13. Type of Loan (e.g., NSL, Stafford, etc.) Please fully print type:
14. Is this loan in Default? Yes ___ No ___ Date of Default:
15. Is there a Federal Judgment Lien for this loan(s)? Yes ___ No ___ Date of Judgment:

AID SUMMARY/DISBURSEMENT REPORTS - Copies must be attached for all loans being submitted for repayment. Documentation must show the original loan amount, date of disbursement(s), and type of loan, interest rate, terms and conditions of repayment.

FOR CONSOLIDATED/REFINANCED LOANS - If you have consolidated/refinanced your loans for undergraduate and graduate nursing education costs, you must attach a copy of the Aid Summary/Disbursement Report or a copy of the consolidated promissory note from the current lender(s) indicating the amount, date of original disbursement and type of loan(s).

WARNING - Any person who knowingly makes a false statement or misrepresentation in this loan repayment transaction, bribes or attempts to bribe a Federal official, fraudulently obtains repayment for a loan under this statute, or commits any other illegal action in connection with this transaction is subject to a fine or imprisonment under Federal statute. I have read this statement and understand its contents.

CERTIFICATION OF APPLICANT - I hereby certify that the information I have provided is true, complete, and accurate and that the above identified loan was incurred solely for the costs of qualifying nursing education as defined by the NELRP. I am aware that any false, fictitious, or fraudulent statement may, in addition to other remedies available to the Government, subject me to civil penalties under the Program Fraud Civil Remedies Act of 1986.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION - Pursuant to the Rights to Financial Privacy Act of 1978 (REPA) (12 USC 3404), having read the attached statement of my RFPA rights, I hereby authorize the government or financial institution named in item 6 or 9 above to release financial records relating to the educational loan identified above to the BCRS for the purpose of assessing and verifying the amount and eligibility of the educational loan for payment under the NELRP. This authorization is valid for 3 months from the date of my signature, and may be revoked in writing at any time before my records are disclosed.

SIGNATURE OF APPLICANT

DATE

Loan Information and Verification Form(s) Instructions

Please review the types of loans eligible for repayment under the NELRP in the Program Overview Section of the Program Guidance under Eligibility Requirements.

1. Applicants must complete a Loan Information and Verification Form (Loan Form) for each lender (or holder) for the nursing education loan(s) they wish to be considered for repayment. If an applicant has multiple loans with the same lender (or holder), a Loan Information and Verification Form for each loan must be submitted. This form authorizes your lender(s) or holder(s) to release information about your loan(s) to the NELRP. (If additional forms are needed, please download/print them or photocopy the form).
2. Be sure to include the most current lender (or holder) of the loan and the lender's (or holder's) complete address and telephone number. Provide the lender's (or holder's) automated access telephone and loan account number that will permit the NELRP to obtain loan information for verification purposes. The most current balance of each loan -- principal and interest -- must be determined as accurately as possible and reported on the Loan Form. Note: All 15 questions on this form must answered or the loan will not be considered for repayment.
3. Applicants must include ALL loans for undergraduate and/or graduate nursing education they wish to be considered with the application. Only those loans submitted with the application will be considered for repayment.
4. Applicants must provide copies of all required documents for loans being submitted for repayment that show the original amount, dates of disbursement, and type for each loan as indicated in the Checklist Loan Documentation Required table.
5. If undergraduate or graduate nursing educational loans have been consolidated or refinanced, the documentation noted below is required to establish that the loans coincide with the nursing education periods stated on the Application.
6. Applicants who have consolidated/refinanced their loans must provide either (1) a an Aid Summary and/or Disbursement Report for the original loan(s) or (2) a copy of the consolidated/refinanced promissory note from the current lender(s) that shows, for each loan being consolidated, the amount, date of original disbursement, and type of loan. See the Checklist Loan documentation Required table.
7. Applicants who have Perkins Loans that are not eligible for cancellation must also provide documentation (a) from the school that the loans are not subject to cancellation under 34 C.F.R. Part 674, or (b) from the current lender indicating that the Perkins loans were consolidated and paid off.
8. If the information provided on the Loan Information and Verification Form does not match the information provided in the Loan Section of the online application the loan will be deemed ineligible.

STATEMENT OF CUSTOMER RIGHTS UNDER THE RIGHT TO FINANCIAL PRIVACY ACT OF 1978

Federal law protects the privacy of your financial records. Before banks, savings and loans associations, credit unions, credit card issuers, or other financial institutions may give financial information about you to a Federal Agency, certain procedures must be followed.

Consent to Disclosure

You may be asked to consent to a financial institution making your financial records available to the Government. You may withhold your consent, and your consent is not required as a condition of doing business with any financial institution. If you give your consent, it can be revoked in writing at any time before your records are disclosed. Furthermore, any authorization you provide is effective for only three months, and your financial institution must keep a record of the instances in which it disclosed your financial information.

Disclosure without your Consent

Without your consent, a Federal Agency that wants to see your financial records may do so ordinarily only by means of a lawful subpoena, summons, search warrant, or formal written request for that purpose.

Generally the Federal Agency must give you advance notice of its request for your records explaining why the information is being sought and telling you how to object in court. The Federal Agency must also send you copies of court documents to be prepared by you with instructions for filling them out. While these procedures will be kept as simple as possible, you may want to consult an attorney before making a challenge to a Federal Agency request.

Exceptions

In some circumstances, a Federal Agency may obtain financial information about you without advance notice or your consent. In most of these cases, the Federal Agency will be required to go to court for permission to obtain your records without giving you notice beforehand. In these instances, the court will make the Government show that its investigation and request for your records are proper. When the reason for the delay of notice no longer exists, you will be notified that your records were obtained.

Transfer of Information

Generally, a Federal Agency which obtains your financial records is prohibited from transferring them to another Federal Agency unless it certifies in writing that the transfer is proper and sends a notice to you that your records have been sent to another Agency.

Penalties

If a Federal Agency or financial institution violates the Right to Financial Privacy Act, you may sue for damages or to seek compliance with the law. If you win, you may be repaid your attorney's fees and costs.

Additional Information

If you have any questions about your rights under this law or how to consent to the release of your financial records, you may contact: the Division of Nursing and Public Health, Bureau of Clinician Recruitment and Service, at 1-800-221-9393.

**NURSING EDUCATION LOAN REPAYMENT PROGRAM (NELRP)
AUTHORIZATION for RELEASE of EMPLOYMENT INFORMATION**

i. I authorize my employer to disclose information pertaining to my employment status to the U.S. Department of Health and Human Services (HHS), and/or its contractors, for purposes of determining my eligibility to participate in the NELRP and, if I am selected to participant in the NELRP, to determine my compliance with the NELRP service requirements. "Information pertaining to my employment status" includes, but is not limited to, my salary, dates of employment, number of hours worked, position held, leave hours/records, nurse licensure data, or the existence of a service obligation to my employer.

ii. I hereby authorize the HHS, and/or its contractors, to release the following information to my current or former employer(s) to assess my eligibility to participant in the NELRP, and if I am selected to participate in the NELRP, to determine my compliance with the NELRP service requirements: my name, social security number and other information necessary to identify me.

This authorization will take effect on the date that I sign this release form. If I become a participant in the NELRP, this authorization shall remain in effect until the date my NELRP obligation, including any extension of the obligation pursuant to a contract amendment, has been fulfilled or this authorization is revoked by me in writing. If I do not become a participant in the NELRP, this authorization shall remain in effect until September 30, 2011.

Signature of Applicant

Date

Name - Printed

Social Security Number

Authorization for Release of Employment Information Form

This form must be completed by the applicant to authorize the release of information regarding the applicant's employment status to NELRP. If the applicant is awarded a NELRP contract, his/her employment status will be verified semiannually.

NURSING EDUCATION LOAN REPAYMENT PROGRAM (NELRP) AUTHORIZATION to RELEASE INFORMATION

As a Nursing Education Loan Repayment (NELRP) applicant, I _____, hereby authorize:
(print full name)

- i. The U.S. Department of Health and Human Services (HHS), and/or its contractors, to release the following information to a consumer reporting agency (credit bureau) to obtain a credit report to assess my eligibility, creditworthiness and suitability to participate in the NELRP and to verify my educational loans: my name, address(es), social security number, and other information necessary to identify me.
- ii. The HHS, and/or its contractors, to release the following information to the lenders/holders of my educational loans in order to obtain loan payoff balances, to determine my eligibility/qualifications to participate in the NELRP, and to determine the eligibility of my educational loans for repayment under the NELRP: my name, address(es), social security number, account number(s), account status, and other information necessary to identify me.
- iii. The HHS, and/or its contractors, to release my name, address(es) and social security number for the purpose of determining whether I appear on the Excluded Parties List System.
- iv. Any program or entity to which I owe a service obligation, or defaulted on a service obligation, to release information relating to that obligation to HHS and/or its contractors.

This authorization will take effect on the date that I sign this release form. If I become a participant in the NELRP, this authorization shall remain in effect until the date my NELRP obligation, including any extension of the obligation pursuant to a contract amendment has been fulfilled or this authorization is revoked by me in writing. If I do not become a participant in the NELRP, this authorization shall remain in effect until September 30, 2011.

Signature of Applicant

Date

Authorization to Release Information Form

This form authorized HHS, and/or its contractors, to release information that identifies the applicant for purposes of obtaining the applicant's credit report and educational loan information and checking whether the applicant appears on the Excluded Parties List System. It also authorizes any program to which the applicant owes a health profession service obligation to release information to HHS and/or its contractors.

Certification Regarding Debarment, Suspension, Disqualification and Related Matters

The receipt of funding under the Nursing Education Loan Repayment Program (NELRP) is a “covered transaction” pursuant to Title 2 of the Code of Federal Regulations (CFR) Part 180, as adopted by HHS pursuant to 2 CFR Part 376. Before entering into a NELRP contract, the applicant is required, under Subpart C of Part 180, to report certain information, which is described below.

Individuals who are currently excluded (suspended or debarred) or disqualified by any Federal agency from participating in covered transactions are ineligible to receive an award under the NELRP. (Individuals with reportable problems other than exclusion or disqualification may, or may not, be selected to participate in the NELRP, based on the Program’s consideration and evaluation of the applicant’s circumstances.)

As a condition of participating in the NELRP, a participant must agree to comply with the requirements of Subpart C of Part 180, which include providing immediate written notice to the NELRP if the applicant learns that he/she failed to make a required disclosure or that a disclosure is now required due to changed circumstances.

****CERTIFICATION****

Pursuant to 2 CFR 180.335 (2006) as implemented by 2 CFR 376.10 (2007), an applicant applying to enter into a covered transaction (which includes an application to participate in the NELRP) is required to notify the Federal agency office if the applicant knows that he or she:

- Is presently debarred, suspended, excluded, or disqualified from participation in covered transactions by any Federal agency or department;
- Within the 3-year period preceding the application, has been convicted of, or had a civil judgment rendered against him or her for any of the following offenses:
 - o commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or a contract under a public transaction;
 - o violation of Federal or State antitrust statutes; or
 - o commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, or obstruction of justice;
- Is presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, local) with the commission of any of the offenses set forth above; or
- Within the 3-year period preceding the application, has had any public transaction (Federal, State, or local) terminated for cause or default.

The applicant must sign one certification below applicable to his or her situation.

I, _____, certify that none of the above statements apply to me. <div style="text-align: center; margin-top: 5px;">(Print Name)</div>	
_____ Signature	_____ Date

OR

I, _____, certify that one or more of the above statements apply to me. <div style="text-align: center; margin-top: 5px;">(Print Name)</div>	
_____ Signature	_____ Date

Completed Certification Regarding Debarment, Suspension, Disqualification and Related Matters Form

This form contains certifications related to “covered transactions” such as the receipt of funding under the NELRP. Applicants should read the entire form and sign the Certification at the bottom of the form that is applicable to their situation.

**NURSING EDUCATION LOAN REPAYMENT PROGRAM (NELRP)
 EMPLOYMENT VERIFICATION AND CRITICAL SHORTAGE FACILITY FORM**
FOR NURSES IN FULL-TIME PRACTICE ONLY (Not Nurse Faculty)

TO BE COMPLETED BY THE AUTHORIZED PERSONNEL OFFICIAL OF THE FACILITY. PLEASE NOTE: IF THIS FORM IS INCOMPLETE OR IF ANY INFORMATION IS INCORRECT, THE APPLICANT WILL BE DEEMED INELIGIBLE AND THE APPLICATION WILL NOT BE PROCESSED.

Employee: _____ Employee Social Security Number: _____
 Name of Health Care Facility: _____ Address: _____

Name & Address of Group Practice (applies only to advanced practice nurses who are employed by a professional group that practices at the health care facility identified above):

Group Name: _____
 Group Address: _____

Advanced nurse practitioners (CRNAs, CNMs, NPs) employed by a professional group that practices at a CSF must provide a written statement from the professional group (on original letterhead, signed by an appropriate official) stating that the applicant will be working exclusively at one designated Critical Shortage Facility for at least 32 hours per week (for a minimum of 45 weeks per service year) for the 2-year duration of the applicant's NELRP contract, if the applicant receives an award. Letters from professional groups must be dated after December 1, 2010, when the application cycle begins. Letters that are not dated or dated before the application cycle begins will not be accepted.

Please note: Under the NELRP, participants must be registered nurses (RNs) providing full-time services at a Critical Shortage Facility. Full-time 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, maternity/paternity, or any other reason. Individuals who have an existing service obligation are not eligible to participate in the NELRP. RNs working PRN, or as Pool Nurses, or for Travel or Nurse Staffing Agencies are not eligible for the program.

I hereby certify that the individual identified above:

1. Began employment as an RN at the health care facility identified above on _____ and is currently employed in:

mm/dd/yyyy

 () a full-time position (defined as an RN providing nursing services for a minimum of 32 hours per week) OR
 () less than a full-time position (defined as an RN providing nursing services for less than 32 hours per week)
2. Does not have an existing commitment to the facility for educational pay back service or a sign-on bonus service obligation to the facility which will not be completely satisfied on or before INSERT DATE.
3. Earns a base annual salary of \$ _____ for the year (please calculate full-time base salary if employee is paid on an hourly basis); (Base does not include Overtime or Shift Differential Pay)
4. Is required to work _____ hours per week.
5. Is currently licensed to practice as an RN without any restrictions.
 Please provide the following: License Number: _____ State: _____ Expiration Date: _____
6. Works at the following type of facility:

() private nonprofit;
 () public / government owned; or
 () private for profit.

7. Works at the following type of Critical Shortage Facility (**check only one**):

<p>€ Disproportionate Share Hospital (DSH) – A nonprofit hospital that: 1) has a disproportionately large share of low-income patients; and 2) receives (a) an augmented payment from the State under Medicaid; or (b) a payment adjustment from Medicare. Hospital-based outpatient services are included under this definition.</p>	<p>€ Federally Designated Health Center Look-Alike – A nonprofit entity that is certified by the Secretary as meeting the requirements for receiving a grant under section 330 of the Public Health Service Act but is not a grantee.</p>
<p>€ Critical Access Hospital – A nonprofit facility that is (a) located in a State that has established with the Centers for Medicare and Medicaid Services (CMS) a Medicare rural hospital flexibility program, (b) designated by the State as a CAH, (c) certified by the CMS as a CAH, and (d) in compliance with all applicable CAH conditions of participation.</p>	<p>€ Home Health Agency – A public agency or private nonprofit organization certified under section 1861(o) of the Social Security Act that is primarily engaged in providing skilled nursing care and other therapeutic services.</p>
<p>€ Non-Federal Non-Disproportionate Share Hospital – Any public or private nonprofit institution in a State that is primarily engaged in providing, by or under the supervision of physicians, to inpatients: (a) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (b) rehabilitation of injured, disabled, or sick persons. Hospital-based outpatient services are included under this definition.</p>	<p>€ Hospice Program – A public agency or private nonprofit organization certified under section 1861(dd)(2) of the Social Security Act, that provides 24-hour care and treatment services (as needed) to terminally ill individuals and their families. This care is provided in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization.</p>
<p>€ Nursing Home – A public or private nonprofit institution (or a distinct part of an institution), certified under section 1919(a) of the Social Security Act, that is primarily engaged in providing, on a regular basis, health-related care and service to individuals who because of their mental or physical condition require care and service (above the level of room and board) that can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases.</p>	<p>€ Indian Health Service Health Center – A nonprofit health care facility (whether operated directly by the Indian Health Service or operated by a tribe or tribal organization contractor or grantee under the Indian Self-Determination Act, as described in 42 Code of Federal Regulations (CFR) Part 136, Subparts C and H, or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act) that is physically separated from a hospital, and which provides clinical treatment services on an outpatient basis to persons of Indian or Alaskan Native descent as described in 42 CFR Section 136.12.</p>
<p>€ Federally Designated Health Center – A nonprofit entity that is receiving a grant, or funding from a grant, under section 330 of the Public Health Service Act, as amended, to provide primary health services and other related services to a population that is medically underserved. Federally Designated Health Centers include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Health Centers.</p>	<p>€ Native Hawaiian Health Center – An entity (a) which is organized under the laws of the State of Hawaii; (b) which provides or arranges for health care services through practitioners licensed by the State of Hawaii, where licensure requirements are applicable; (c) which is a public or nonprofit private entity; and (d) in which Native Hawaiian health practitioners significantly participate in the planning, management, monitoring, and evaluation of health services. See the Native Hawaiian Health Care Act of 1988 (Public Law 100-579), as amended by Public Law 102-396.</p>
<p>€ Skilled Nursing Facility – An public or private nonprofit institution (or a distinct part of an institution), certified under section 1819(a) of the Social Security Act, that is primarily engaged in providing skilled nursing care and related services to residents requiring medical, rehabilitation or nursing care and is not primarily for the care and treatment of mental diseases.</p>	<p>€ State or Local Public Health or Human Services Department – The State, county, parish or district entity in a State that is responsible for providing population focused health services which include health promotion, disease prevention and intervention services provided in clinics or other health care facilities that are operated by the Department.</p>
<p>€ Rural Health Clinic – A public or private nonprofit entity that the Centers for Medicare and Medicaid Services has certified as a rural health clinic under section 1861(aa)(2) of the Social Security Act. A rural health clinic provides outpatient services to a non-urban area with an insufficient number of health care practitioners.</p>	<p>€ Federal Hospital – Any Federal institution in a State that is primarily engaged in providing, by or under the supervision of physicians, to inpatients: (a) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or (b) rehabilitation of injured, disabled, or sick persons. Hospital-based outpatient services are included under this definition.</p>
<p>€ Ambulatory Surgical Center – A nonprofit entity in a State that provides surgical services to individuals on an outpatient basis and is not owned or operated by a hospital.</p>	

Signature _____

Date _____



Printed Name

Title

Phone

Fax

Employment Verification and Critical Shortage Facility Form Instructions

ONLY COMPLETE THIS FORM IF YOU ARE A Full-Time PRACTICING NURSE

The applicant's employer must fill out this form (both pages) completely and return it to the applicant for submission with the other application materials.

1. Name and Address of Health Care Facility is the name and location of the facility where the applicant is working; not the name and address of the corporation that owns the facility.
2. Employment Date is the date the applicant became employed as a nurse at the facility.
3. The base annual salary of the applicant must be reported. Base salary does not include overtime or shift differential. Applicants working at the facility for less than one year must report their negotiated base salary for the year.
4. Critical Shortage Facility Type must be identified. The facility must select the one Critical Shortage Facility definition that describes the Health Care Facility listed on page (2 of 2).
5. The health care facility listed on page (1 of 2) must match one definition listed on page (2 of 2). If the facility is not a NELRP Critical Shortage Facility it is not and eligible facility under NELRP.

Please note that while the employer is responsible for completing the form in its entirety, the applicant is responsible for assuring that the form is complete and accurately, and the applicant is responsible for the timely submission of the completed form.

Special Instructions for Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), and Nurse Practitioners (NPs) Employed by a Professional Group that Practices at a Critical Shortage Facility: The Critical Shortage Facility should complete the Employment Verification and Critical Shortage Facility Form, and the professional group should prepare the written statement described in "Instructions for Supplement Forms and Supporting Documentation."

NURSING EDUCATION LOAN REPAYMENT PROGRAM (NELRP)
EMPLOYMENT VERIFICATION FOR NURSE FACULTY APPOINTMENT
FOR NURSE FACULTY ONLY

TO BE COMPLETED BY THE AUTHORIZED PERSONNEL OFFICIAL OF THE EDUCATIONAL INSTITUTION. PLEASE NOTE: IF THIS FORM IS INCOMPLETE OR IF ANY INFORMATION IS INCORRECT, THE APPLICANT WILL BE DEEMED INELIGIBLE AND THE APPLICATION WILL NOT BE PROCESSED.

Employee: _____ **Employee Social Security Number:** _____
Accredited School of Nursing: _____ **Address:** _____

Please note: Under the NELRP, participants must be registered nurses (RNs) who are employed full-time as nurse faculty at an accredited public or private nonprofit school of nursing. Individuals who have an existing service obligation are not eligible to participate in the NELRP. An existing service obligation is defined as an obligation of the employee to work as nurse faculty for a certain period of time in exchange for receiving a financial recruitment or retention incentive from the school or institution (e.g., a sign-on bonus, payment of moving expenses, funds to repay student loans). A basic employment contract which outlines the salary and benefits an employee earns in exchange for the work he/she performs does not constitute a service obligation.

I hereby certify that the individual identified above:

1. Began employment as a full-time nurse faculty at the school of nursing identified above on _____ and is currently employed in: _____ mm/dd/yyyy
 a full-time position (as defined by the school of nursing) OR
 less than a full-time position (as defined by the school of nursing)
2. Does not have an existing service obligation (as defined above) to the school of nursing or educational institution which will not be completely satisfied on or before INSERT DATE.
3. Earns a current base annual salary (gross salary before deductions for taxes, insurance, etc.) of \$_____ for the year (please calculate full-time base annual salary if employee is paid on an hourly basis). If the employee has worked at the institution for less than one year, report his/her negotiated base salary for the first year of employment.
4. Has received a nurse faculty appointment for: 9 months 12 months Other (please explain:_____)
5. Is currently licensed to practice as an RN without any restrictions.
 Please provide the following: License Number: _____ State: _____ Expiration Date: _____
6. Works at the following type of facility:
 private nonprofit;
 public / government owned; or
 private for profit.

 Signature _____ Date _____
 Printed Name _____ Title _____
 Phone _____ Fax _____

Employment Verification for Nurse Faculty Appointment

ONLY COMPLETE THIS FORM IF YOU ARE NURSE FACULTY

The applicant's employer must fill out this form completely and return it to the applicant for submission with the other application materials.

1. Name and Address of the Accredited School of Nursing or Nursing Program is the name and location of the institution where the applicant is working.
2. Employment Date is the date the applicant became employed as nurse faculty at the school of nursing or nursing program.
3. The base annual salary of the applicant must be reported. Base salary does not include overtime or shift differential. Applicants working at the facility for less than one year must report their negotiated base salary for the year.

Please note that while the employer is responsible for completing the form in its entirety, the applicant is responsible for assuring that all information is entered accurately, and the applicant is responsible for the timely submission of the completed form.

**NURSING EDUCATION LOAN REPAYMENT PROGRAM (NELRP)
CERTIFICATION of ACCREDITATION STATUS for SCHOOL of NURSING EDUCATION PROGRAMS**

TO BE COMPLETED BY THE SCHOOL OF NURSING DEAN'S OFFICE OR PROGRAM CHAIR (and returned to the applicant for submission with the other application materials)

PLEASE NOTE: Collegiate and associate degree schools of nursing are a department, division, or other administrative unit in the educational institution which provides primarily or exclusively a program of education in professional nursing. A diploma school of nursing means a school affiliated with a hospital or university, or an independent school, which provides primarily or exclusively a program of education in professional nursing.

U.S. Secretary of Education nationally recognized nursing accrediting agencies are the:

- Commission on Collegiate Nursing Education
- National League for Nursing Accrediting Commission
- American College of Nurse-Midwives, Division of Accreditation
- National Association of Nurse Practitioners in Women's Health, Council on Accreditation
- Council on Accreditation of Nurse Anesthesia Educational Programs

SCHOOL OF NURSING

ADDRESS

****CERTIFICATION****

I hereby certify that all of the nursing education programs in the school of nursing identified above are accredited by a nationally recognized nursing accrediting agency listed above, and/or by a state nursing accrediting agency.

Name of Authorized Official (please print)

Title

Phone

Signature of Authorized Official

Date