On-line In Service Verification - Participant

▶

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Professional & Site Information
required fields

Please verify the following information is correct for the time period from 07/27/2014 to 01/26/2015.

PROFESSIONAL INFORMATION

Discipline	Specialty	Status
Registered Nurse	None	Full Time

SITE INFORMATION

Name	Address	Hours Per Week
███████████	███████████	36.00

Is your professional information correct? *   ○ Yes ○ No

For this entire verification period, did you work at the site(s) listed above? *   ○ Yes ○ No

CONTINUE

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① Verification ② Review and Submit

Verification
required field

Please enter the days away from your site(s) for the Verification Period **07/27/2014 - 01/26/2015** .

Site 1	
Name	████████████████
Address	████████████████

Total number of days you've missed at this site * [　　　]

For instructions on how to report days missed, please see the **Application and Program Guidance** 📕 .

CONTINUE

✉ ██████████████████████████████████

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① Verification   ② Review and Submit

Review and Submit
required field

VERIFICATION

Please verify the following information for the **07/27/2014 - 01/26/2015** verification period.

Site 1

Name	████████████████████
Address	████████████████████

Total number of days you've missed at this site: **0.0**

EDIT

☐ I certify that I am engaged in clinical practice, as defined in the **Clinical Practice Definitions** 📕
AND
I certify that the information given in this request is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any false statement herein 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 (31 U.S.C. 3801-3812). I understand that submitting my request does not guarantee its approval, and that it requires review for compliance with my obligation and program policies.

Sign with your password *   [   ]

SUBMIT

✉ ██████████████████████████████████ ▶

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Verification Submitted

Thank you. Your Verification has been successfully submitted.

If there is more than one site associated with this In Service verification, all sites must approve the submitted information. Otherwise, it will need to be resubmitted.

If you have any immediate questions or concerns, please contact GetHelp@hrsa.gov or 1-800-221-9393 (TTY: 1-877-897-9910), Monday through Friday (except Federal holidays), 8:00 am to 8:00 pm EST

BACK TO HOMEPAGE

On-line In Service Verification - Employer

✉ **Service Verification for** ▬▬▬▬▬ **has been Submitted for Review** ▶

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Participant In Service Verification # ▬▬▬▬
required field

PARTICIPANT INFORMATION

Last Name	▬▬▬
First Name	▬▬▬
Discipline	Registered Nurse
Specialty	None
Status	Full Time
Home Address	123 Anywhere St. Anytown, MD 21217
Daytime Phone	
Home Phone	(000) 000-0000
Mobile Phone	(000) 000-0000
Email Address	▬▬▬▬▬▬▬

PARTICIPANT VERIFICATION

During the 07/27/2014 - 01/26/2015 Verification period:

Name	▬▬▬▬▬▬
Address	▬▬▬

Total number of days missed at this site: 0.0

Please carefully review the information submitted by the participant. All the sites listed above must approve the In Service Verification in order for it to be processed successfully. If any of the information is incorrect, the In Service Verification will have to be resubmitted by the participant.

Is all the above information correct? * ○ Yes ○ No

Sign with your password * [＿＿＿＿＿＿＿]

SUBMIT