



SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM - PROGRAM STATUS VERIFICATION

PART I - EMPLOYEE CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

CONSENT: I authorize the educational institution in which I am, or will be, enrolled to release to VA information regarding my medical residency program status and standing. I understand that this authorization is voluntary, and that I may revoke this consent at any time. However, I further understand that if I voluntarily revoke this authorization after the award of the scholarship, my award and placement with VA may be terminated and I may be liable for the damages in accordance with provisions under the SELRP.

PARTICIPANT NAME:

PARTICIPANT SIGNATURE:

DATE:

PART II - PROGRAM DIRECTOR VERIFICATION

I verify the individual is in good standing and recommended for continued participation in the VA SELRP.

PROGRAM DIRECTOR NAME:

PROGRAM DIRECTOR SIGNATURE:

DATE:

PROJECTED MONTH AND YEAR OF RESIDENT'S PROGRAM COMPLETION: