STAR EMPLOYMENT VERIFICATION FORM

Substance Use Disorder Treatment and Recovery (STAR)
Loan Repayment Program (LRP)

I N STRU C TIO N S

As the Substance Use Disorder Treatment and Recovery (STAR) point of contact (POC) for the approved program practice site(s) where a STAR participant is serving, we request that you complete this Employment Verification Form (EVF). The form will be used to verify the applicant's employment and that they meet the clinical practice requirements as defined in the fiscal year 2021 STAR Loan Repayment Program (LRP) Application & Program Guidance (APG).

Please list the **name** and **physical address**, for each of the **STAR-approved** service sites where the STAR applicant is currently providing primary care and mental/behavioral, direct-patient services for your organization. If you are not the POC for each site that you list, a separate EVF must be submitted by each POC, for the practice site(s) where the participant provides clinical, direct-patient services to satisfy the STAR Loan Repayment Program service commitment. To qualify, participants must meet the clinical practice requirements as defined (TBD). Please deliver the completed form to the participant and they will submit it as a part of their application to extend their service with the STAR.

Participant Name: _____ **Discipline and Specialty** _____

STAR Site Name: Click or tap here to enter text.	**STAR Site Name:** Click or tap here to enter text.
Street Address: Click or tap here to enter text.	**Street Address:** Click or tap here to enter text.
City: Click or tap here to enter text.	**City:** Click or tap here to enter text.
State, Zip code: Click or tap here to enter text.	**State, Zip code:** Click or tap here to enter text.

STAR Site Name: Click or tap here to enter text.	**STAR Site Name:** Click or tap here to enter text.
Street Address: Click or tap here to enter text.	**Street Address:** Click or tap here to enter text.
City: Click or tap here to enter text.	**City:** Click or tap here to enter text.
State, Zip code: Click or tap here to enter text.	**State, Zip code:** Click or tap here to enter text.

APPLICANT INFORMATION

Is the (Insert Applicant Name) currently working, or will work as a (Insert Applicant Discipline) at (Insert Site Name) STAR-approved service site(s) you have listed above? Choose an item.

Does (Insert Applicant Name) have a current, full, permanent, unencumbered, and unrestricted license to practice at this site?
Choose an item.

EMPLOYMENT INFORMATION

When did or will (Insert Applicant Name) begin to practice and meet the STAR service requirements at (Insert Site)? Click or tap to enter a date.

Does/will (Insert Name) meet the STAR LRP Clinical Practice Requirements for full-time participants? Choose an item.

Total hours (Insert Name) works per week at the site(s) per the **STAR Clinical Practice Requirements.** Click or tap here to enter text.

SERVICE TYPE VERIFICATIONS

Does your organization or the entity with who you have an agreement to provide healthcare services at (Insert Site Name) ensure that (Insert Applicant Name)? Choose an item.

Upholds the personnel system and employment policies of the site: AND

Is paid the annual income, equal to or greater than the minimum paid to the Federal civil servants practicing with the same discipline/specialty?

Does (Insert Applicant Name) provide services at (Insert Site Name) as a self-employed worker or independent contractor? Choose an item.

Does (Insert Applicant Name) own or have a financial interest in (Insert Site Name)? Choose an item.

Does (Insert Site Name) provide (Insert Applicant Name) or the organization with who you have an agreement to provide healthcare services at your site provide (Insert Applicant Name) with malpractice insurance and tail coverage (either commercially or through the Federal Tort Claims Act)? Choose an item.

Does /will (Insert Applicant Name) provide clinical services at a STAR –approved? Choose an item.

- Federally Qualified Health Center (FQHC)
- Federally Qualified Health Center (FQHC) Look-A-Like
- Community Mental Health Center (CMHC)
- Community Outpatient Facility
- Independent Group/Private Practice
- Certified Rural Health Clinic
- Indian Health Service (IHS) Tribal or Urban Indian
- American Indian Health Facility
- School-Based Clinic
- State or Local Health Department
- Free Clinic
- Mobile Unit
- Federal Bureau of Prisons (BOP)
- Immigration Customs Enforcement Correction Facilities (ICE)
- State Correctional Facility
- Critical Access Hospital (CAH)
- SAMHSA-certified Outpatient Treat Program (OTPs)
- Office-based Opioid Treatment Facilities (OBOTs)
- Non-Opioid Substance Use Disorder Treatment Facilities (SUD Treatment Facilities)

LICENSURE

What is the expiration date of this clinician's professional license? Click or tap to enter a date.

What is the license number? Click or tap here to enter text.

In which state or U.S. territory is this license registered? Click or tap here to enter text.

NATIONAL PRACTITIONER DATA BANK (NPDB)

Has your facility reviewed the National Practitioner Data Bank (NPDB) for this employee? Choose an item.

Date of the last NPDB query? Click or tap to enter a date.

Wan adverse action reported? Choose an item.

The Substance Use Disorder Treatment and Recovery (STAR) Point of Contact (POC)

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

Name – please print & include title	***STAR Point of Contact – Signature***
Email Address	***Date***

Public Burden Statement: The purpose of this information collection is to obtain information through the Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program (LRP), which used to assess a LRP applicant's eligibility and qualifications for the LRP and to obtain information for STAR site applicants. Clinicians interested in participating in the STAR LRP must submit an application to the STAR to participate in the STAR program, and health care facilities must submit an STAR Site Application to determine the eligibility of sites to participate in the STAR as an approved service site. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is XXXX-XXXX and it is valid until mm/dd/yyyy. This information collection is required to obtain or retain a benefit (Section 333 [254f] (a)(1) of the Public Health Service Act). Public reporting burden for this collection of information is estimated to average xx hours per response, including the time for reviewing instructions, searching existing data sources, 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 Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.