

Employment Verification Form

U.S. Department of Health & Human Services
Health Resources and Services Administration
Pediatric Specialty Loan Repayment Program

OMB #: 0906-0058
Expiration Date: xx/xx/xxxx

INSTRUCTIONS

As the Pediatric Specialty point of contact (POC) for the approved program practice site(s) where a Pediatric Specialty 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 2023 Pediatric Specialty Loan Repayment Program (LRP) Application & Program Guidance (APG).

Please list the name and physical address, for each of the Pediatric Specialty LRP-approved service sites where the Pediatric Specialty LRP 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 Pediatric Specialty LRP. 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 Pediatric Specialty LRP.

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

Pediatric Specialty LRP Site Name: Click or tap here to enter text.	Pediatric Specialty LRP 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.

Pediatric Specialty LRP Site Name: Click or tap here to enter text.	Pediatric Specialty LRP 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?

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

Is (Insert Applicant Name) capable of delivering care in ways that reflect their understanding of behaviors and attitudes of a cross-cultural community?

Will (Insert Applicant Name) directly provide culturally appropriate oral and written language services to limited English proficiency patients?

(Insert Applicant Name)

EMPLOYMENT INFORMATION

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

Does/will (Insert Name) meet the Pediatric Specialty LRP Clinical Practice Requirements for full-time participants?

Total hours (Insert Name) work per week at the site(s) per the Pediatric Specialty LRP Clinical Practice Requirements. Click or tap here to enter text.

(Insert Applicant Name) serve a Medically Underserved Population (MUP) and your site receives reimbursement from the Centers for Medicare and Medicaid (CMS) for those services.

SERVICE TYPE VERIFICATIONS

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

Does (Insert Applicant Name) own or have a financial interest in (Insert Site Name)?

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)?

Does /will (Insert Applicant Name) provide clinical services at a Pediatric Specialty LRP –approved?

- 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
- 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)

- American Indian Health Facility
- School-Based Clinic
- State or Local Health Department
- 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?

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

Was adverse action reported?

The Pediatric Specialty (SP) Point of Contact (POC)

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

CERTIFY REQUEST

- I certify that I have read and understand the PS LRP-approved facility requirements for this provider's discipline and/or specialty and subspecialty.
- I certify that the applicant serves a medically underserved population (MUP) and my site receives reimbursement from the Centers for Medicare and Medicaid (CMS) for those services.
- I certify that the applicant is capable of delivering care in ways that reflect their understanding of behaviors and attitudes of a cross-cultural community.
- I certify that the applicant will directly provide culturally appropriate oral and written language services to limited English proficiency patients.
- I certify that the responses provided with this employment verification are accurate and complete to the best of my knowledge, and that any inaccurate or false responses provided may disqualify this person or the healthcare organization that I represent from the initial or continued participation in the Bureau of Health Workforce (BHW) programs.

By certifying the above, I understand that I may be requested to provide additional details of employment for this person periodically and; the information provided must be formatted and submitted within the required time frame, or this person may be disqualified from participation in BHW programs.

required Sign with your password *

_____ **Name - please print & include title**

_____ **SP Point of Contact - Signature**

_____ **Email Address**

_____ **Date**

Public Burden Statement: The purpose of this information collection is to obtain performance data for the following: HRSA program participant, program operations, and applications. In addition, these data will facilitate the ability to demonstrate alignment between BHW discretionary programs and the Substance Use Disorder Treatment and Recovery Loan Repayment and the Pediatric Specialty Loan Repayment programs. 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 0906-0058 and it is valid until xx/xx/xxxx. This information collection is required to obtain or retain a benefit Section 781 of the Public Health Service Act (42 U.S.C. § 295h) and Section 775 of the Public Health Service Act (42 U.S.C. § 295f). Public reporting burden for this collection of information is estimated to average xx hour 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.