U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Nurse Corps Loan Repayment Program
U.S. Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0140 Expiration Date: xx/xx/xxxx

NURSE CORPS LOAN REPAYMENT PROGRAM (Nurse Corps LRP)
EMPLOYMENT VERIFICATION FOR NURSE FACULTY

Public Burden Statement: *The purpose of this information collection is to obtain information through the Nurse Corps Loan Repayment Program that is used to assess a Loan Repayment Program applicant's eligibility and qualifications for the Loan Repayment Program and to monitor a participant's compliance with the program's service requirements. Applicants interested in participating in the Nurse Corps Loan Repayment Program must submit an application to the Nurse Corps. 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 0915-0140 and it is valid until xx/xx/xxxx. This information collection is required to obtain or retain a benefit (Section 846 of the Public Health Service Act, as amended [42 U.S.C. 297n]). The information is protected by the Privacy Act, but it may be disclosed outside the U.S. Department of Health and Human Services, as permitted by the Privacy Act and Freedom of Information Act, to Congress, the National Archives, and the Government Accountability Office, and pursuant to court order and various routine uses as described in the System of Record Notice 09-15-0037. 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 14NWH04, Rockville, MD 20857.*

TO BE COMPLETED BY THE AUTHORIZED PERSONNEL OFFICIAL OF THE EDUCATIONAL INSTITUTION. IF THIS FORM IS INCOMPLETE OR IF ANY INFORMATION IS INCORRECT, THE PARTICIPANT AND THE INSTITUTION MAY BE DEEMED INELIGIBLE AND THE SITE CHANGE REQUEST MAY NOT BE PROCESSED.

PLEASE NOTE THAT WHILE THE EDUCATIONAL INSTITUTION IS RESPONSIBLE FOR COMPLETING THE FORM IN ITS ENTIRETY, THE PARTICIPANT IS RESPONSIBLE FOR ASSURING THAT THE FORM IS COMPLETE AND ACCURATE, AND THE PARTICIPANT IS RESPONSIBLE FOR THE TIMELY SUBMISSION OF THE COMPLETED FORM.

NURSE CORPS LRP FACULTY PARTICIPANT:

Name: _____ Email Address: _____

PLACE OF EMPLOYMENT:

Name of School of Nursing: _____

Address: _____ Phone Number: _____

Address Line 2: _____ Email Address: _____

City: _____ State: _____ Zip Code: _____ Website: _____

Please note: Under the Nurse Corps LRP, participants must be registered nurses (RNs) who are employed full-time (as defined by his or her employer) as nurse faculty at an accredited school of nursing.

- Name and Address of the Accredited School of Nursing is the name and location of the institution where the applicant is working.
- Employment Date is the date the applicant started working as nurse faculty at the school of nursing.
- The educational institution where the applicant works as a nurse faculty must fill out this form completely and return it to the NurseCorps for review.

I hereby certify that the individual identified above:

1. Began working or will begin working as a full-time nurse faculty member at the school of nursing identified above on _____ (mm/dd/yyyy) and is currently working or will be working in the following capacity:
   ( ) 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. Is a tenured nurse faculty member? ( ) Yes or ( ) No:
   IF No, is currently working under a nurse faculty appointment for: ( ) 9 months ( ) 12 months ( ) Other (please specify): _____ with a start date of_____(mm/dd/yyyy) and end date of_____(mm/dd/yyyy).

3. Is currently licensed to practice as an RN without any restrictions or encumbrances: ( ) Yes or ( ) No:

   License Number: _____ State: _____ Expiration Date: _____ (mm/dd/yyyy)

4. Works at a school of nursing with a profit status of: ( ) For-Profit ( ) Non-Profit ( ) Public/Government Owned

5. Teaches pre-licensure students, RNs, or APRNs at the school of nursing identified above? ( ) Yes or ( ) No

6. The school of nursing identified above is accredited by a national accrediting agency or state agency recognized by the U.S. Secretary of Education? ( ) Yes or ( ) No

7. Graduates of this school of nursing are authorized to sit for the NCLRX-RN? ( ) Yes or ( ) No

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Nurse Corps LRP Accreditation Status for Schools of Nursing Programs

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.

Secretary of Education nationally recognized nursing accrediting agencies are the:
- Commission on Collegiate Nursing Education
- Accreditation Commission for Education in Nursing, Inc. (Formerly 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;
- Kansas State Board of Nursing;
- Maryland Board of Nursing;
- Missouri State Board of Nursing;
- North Dakota Board of Nursing; and
- New York State Board of Regents and the Commissioner of Education.

****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 approved for such purposes by the Secretary of the U.S. Department of Education.

_____ _____
Point of Contact Signature *Date*

_____ _____
Point of Contact Printed Name *Point of Contact Title*

_____ _____
Point of Contact Phone Number *Point of Contact Email Address*

For questions on how/where to submit this form please submit an inquiry through your My BHW account.