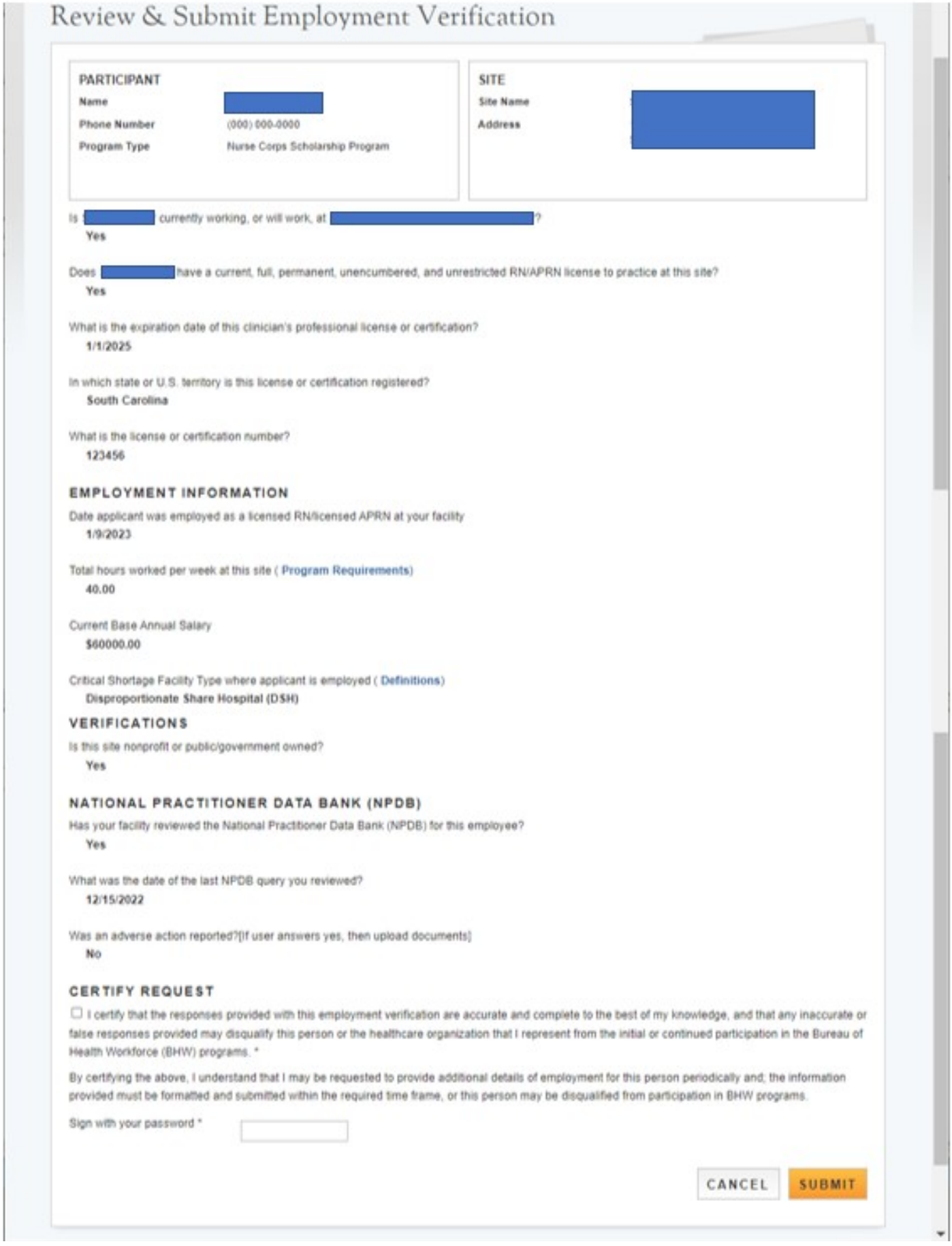
Employment Verification Screenshot



Review & Submit Employment Verification

PARTICIPANT

Name [redacted]

Phone Number (000) 000-0000

Program Type Nurse Corps Scholarship Program

SITE

Site Name [redacted]

Address

Is [redacted] currently working, or will work, at [redacted]?

Yes

Does [redacted] have a current, full, permanent, unencumbered, and unrestricted RN/APRN license to practice at this site?

Yes

What is the expiration date of this clinician's professional license or certification?

1/1/2025

In which state or U.S. territory is this license or certification registered?

South Carolina

What is the license or certification number?

123456

EMPLOYMENT INFORMATION

Date applicant was employed as a licensed RN/licensed APRN at your facility

1/9/2023

Total hours worked per week at this site (Program Requirements)

40.00

Current Base Annual Salary

$60000.00

Critical Shortage Facility Type where applicant is employed (Definitions)

Disproportionate Share Hospital (DSH)

VERIFICATIONS

Is this site nonprofit or public/government owned?

Yes

NATIONAL PRACTITIONER DATA BANK (NPDB)

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

Yes

What was the date of the last NPDB query you reviewed?

12/15/2022

Was an adverse action reported?[If user answers yes, then upload documents]

No

CERTIFY REQUEST

☐ 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.

Sign with your password *

CANCEL SUBMIT

Form Approved| OMB No. 0915-0301| Expires xx/xx/xxxx

Public Burden Statement: The purpose of the Nurse Corps Scholarship Program (Nurse Corps SP) is to provide scholarships to nursing students in exchange for a minimum two-year full-time service commitment (or part-time equivalent), at an eligible health care facility with a critical shortage of nurses. The information that applicants supply is used to evaluate their eligibility, qualifications and to assess their continued compliance with the applicable standards for participation in the Nurse Corps SP. The OMB control number for this information collection is 0915-0301 and it is valid until xx/xx/xx. This information collection is required to obtain a benefit (Section 846(d) of the Public Health Service Act (42 United States Code 297n (d)), as amended). Data will be private to the extent permitted by the law. Public reporting burden for this collection of information is estimated to average approximately 36 minutes 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, Maryland, 20857.