

**PEDIATRIC SPECIALTY LOAN REPAYMENT PROGRAM**  
**EMPLOYMENT VERIFICATION FORM**

**INSTRUCTIONS**

As the Pediatric Specialty point of contact for the approved program practice site(s) where a Pediatric Specialty participant is serving, we request that you complete this Employment Verification Form. 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 2025 Pediatric Specialty Loan Repayment Program Application & Program Guidance.

Please list the name and physical address, for each of the Pediatric Specialty Loan Repayment Program-approved service sites where the Pediatric Specialty Loan Repayment Program 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 Employment Verification Form must be submitted by each point of contact, for the practice site(s) where the participant provides clinical, direct-patient services to satisfy the Pediatric Specialty Loan Repayment Program. To qualify, participants must meet the clinical practice requirements as defined by the Pediatric Specialty Loan Repayment Program. For the purposes of the Pediatric Specialty Loan Repayment Program, full-time employment is defined as a minimum of 40 hours/week, for a minimum of 45 weeks each service year at a Pediatric Specialty Loan Repayment Program-approved site. Of the 40 hours/week, a participant must spend a minimum of 36 hours providing a combination of the following: pediatric medical subspecialty care; pediatric surgical specialty care; child and adolescent behavioral health care, including substance use disorder prevention and treatment services; direct treatment, care, and clinical management of participants in a clinical trial; and care coordination activities. The remaining four (4) hours/week may be used for clinical-related administrative, management or other activities. The 40 hours per week includes scheduled breaks. 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:**

**Street Address:**

**City: State: Zip Code:**

**Pediatric Specialty LRP Site Name:**

**Street Address:**

**City: State: Zip Code:**

**Pediatric Specialty LRP Site Name:**

**Street Address:**

**City: State: Zip Code:**

**Pediatric Specialty LRP Site Name:**

**Street Address:**

**City: State: Zip Code:**

**APPLICANT INFORMATION**

Is the \_\_\_\_\_ currently working, or will work as a \_\_\_\_\_ at \_\_\_\_\_  
Pediatric Loan Repayment Program-approved service site(s) you have listed above?

Does \_\_\_\_\_ have a current, full, permanent, unencumbered, and unrestricted license to practice at this site?

Is \_\_\_\_\_ capable of delivering care in ways that reflect their understanding of behaviors and attitudes of a cross-cultural community?

Will \_\_\_\_\_ directly provide culturally appropriate oral and written language services to limited English proficiency patients?

**EMPLOYMENT INFORMATION**

When did or will \_\_\_\_\_ begin to practice and meet the Pediatric Specialty Loan Repayment Program service requirements at?

Does/will \_\_\_\_\_ meet the Pediatric Specialty Loan Repayment Program Clinical Practice Requirements for full-time participants?

Total hours \_\_\_\_\_ works per week at at the site(s) per the Pediatric Specialty Loan Repayment Program, Clinical Practice Requirements

Does \_\_\_\_\_ serve a Medically Underserved Population and your site receives reimbursement from the Centers for Medicare and Medicaid for those services

**SERVICE TYPE VERIFICATIONS**

Does \_\_\_\_\_ provide services at \_\_\_\_\_ as a self-employed worker or independent contractor?

Does \_\_\_\_\_ own or have a financial interest in?

Does \_\_\_\_\_ provide \_\_\_\_\_ or the organization with \_\_\_\_\_ who you have an agreement to provide healthcare services at you site provide \_\_\_\_\_ with malpractice insurance and tail coverage (either commercially or through the Federal Tort Claims Act)?

Does/will \_\_\_\_\_ provide clinical services at a Pediatric Specialty Loan Repayment Program -- approved?

- Federally Qualified Health Center (FQHC)
- Federally Qualified Health Center (FQHC) Look-A-Alike
- 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 Treatment Programs (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?

What is the license number?

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

## The Pediatric Specialty Point of Contact

*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 Pediatric Specialty Loan Repayment Program-approved facility requirements for this provider's discipline and/or specialty and subspecialty.

I certify that the applicant serves a medically underserved population and my site receives reimbursement from the Centers for Medicare and Medicaid 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 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 the participation in BHW programs.

*Name - please print & include title*

*Point of Contact - Signature*

*Email Address*

*Date*

**Public Burden Statement:** The purpose of this information collection is to obtain information through the Pediatric Specialty Loan Repayment Program (PS LRP) that is used to assess a Loan Repayment Program applicant's eligibility and qualifications for the PS LRP and to obtain information for eligible facilities or sites. Clinicians interested in participating in the PS LRP must submit an application to the PS LRP through the My BHW online portal. 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 775 of the Public Health Service Act [42 USC § 295]). 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 13N82, Rockville, Maryland, 20857.