**OMB No.** 0906-0058
**Expiration Date:** xx/xx/xxxx
**Bureau of Health Workforce**
U.S. Department of Health and Human Services
Health Resources and Services Administration

# 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:** _____

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## 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 Faciltiies)

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## 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***