



EMPLOYMENT VERIFICATION FORM

To be completed by applicant

Applicant's Name: _____

This authorization is to release information concerning my employment as required below. To establish eligibility for the Health Professions Education Foundation Loan Repayment/Scholarship Program, verification of employment is required. Please complete this form as soon as possible and return it to HPEF. Your cooperation and prompt return of this information is appreciated.

Signature of Applicant

Date

To be completed by your Direct Supervisor

Employer Name : _____ Telephone #: _____

Employer Address: _____

Start Date: _____ Applicant's Job Title: _____

Average weekly hours worked: _____ *Direct Patient Care hours worked per week: _____

****"Direct patient care" means the provision of healthcare services directly to individuals being treated for, or suspected of having physical or mental illness. Direct patient care includes preventive care. The first line supervision of direct patient care is considered direct patient care.**

Is applicant's current hours considered full-time or part-time?

(Please check one) Full-Time (32+ hours a week) Part-Time (less than 32 hours)

% direct patient care: _____ % other (please specify): _____

Supervisory Role: ONLY if an applicant is a supervisor, please complete percentage of time below. I verify that the applicant's percentage of time is used as follows:

% supervising: _____ % administration: _____

Does the applicant speak another language at work in addition to English? (Languages must be spoken in patient care interactions without the use of translator services.) If so, which language(s):

- 1. I understand that, should the applicant be awarded, I agree to sign Progress Reports verifying that this employee is providing direct patient care until the service obligation is complete.*
- 2. I declare under penalty of perjury that the information contained in this section is true and correct to the best of my knowledge.*

Signature of Direct Supervisor

Date

Printed Name

Phone/Ext.

Title

Email Address

Rev. 1/21/2020

Applicant: Upload this form and input the information provided above <https://eapp.oshpd.ca.gov/funding/>.