



## LICENSED MENTAL HEALTH SERVICES PROVIDER EDUCATION PROGRAM (LMH) EMPLOYMENT OR INTERNSHIP 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 me. Your cooperation and prompt return of this information is appreciated.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Employment or Volunteer Facility/Agency : \_\_\_\_\_

Program Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Employment County: \_\_\_\_\_

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):

\_\_\_\_\_

Applicant's start date: \_\_\_\_\_ Applicant's profession: \_\_\_\_\_

**Total weekly work or internship hours providing direct patient care (must be at least 32 hours per week):** \_\_\_\_\_

Applicant's primary responsibilities or job functions:

### To be completed by Direct Supervisor or Authorized Administrative Officer

Please check all that apply to your agency:

Mental Health Professional Shortage Area

A publicly funded facility

A publicly funded or public mental health facility

A non-profit private mental health facility

Descriptions of the types of qualified facilities for the LMH Program are listed on the Health Professions Education Foundation's website at [www.healthprofessions.ca.gov](http://www.healthprofessions.ca.gov).

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 form is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Employer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone/Ext.

\_\_\_\_\_  
Title

\_\_\_\_\_  
Email Address

Rev. 8/12/2020

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