



EMPLOYMENT VERIFICATION FORM (EVF)

Directions at Time of Application

1. Applicant **must** complete **all** fields in Section A (General Information) and Section B (Employment Certification).
2. Upon completion of Section A and B, Applicant **must** obtain the signature of Direct Supervisor or Authorized Administrative Officer in Section B.
3. Once both Section A and B have been completed and signed, Applicant must upload completed form into eApp by the application deadline.

Directions if Awarded

1. Awardee will need to complete steps 1 through 3 (above) anytime their employer changes.

GENERAL INFORMATION

A.

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 Program, verification of employment (including completion of all fields below) is required. Only official HPEF Employment Verification Forms (EVF) will be accepted.

Applicant's Signature: _____ Date: _____

The Applicant's Employer is Designated as:

- | | |
|---|---|
| County, State, Veterans, or Correctional Facility | Health Professional Shortage Area -Primary Care (HPSA-PC) |
| Federally Qualified Healthcare Center (FQHC) | Primary Care Shortage Area (PCSA) |
| Rural Healthcare Center or Indian Tribal Clinic | Registered Nursing Shortage Area (RNSA) |
| CMSP Contracted Facility or Clinic | |

Applicant's Employer Name: _____

Applicant's Employer Address: _____

(Note: Please enter the address of the employer or agency/facility the applicant is currently working at, and not the administrative/headquarters office.)

City: _____ Zip: _____ County: _____

EMPLOYMENT CERTIFICATION

B.

Applicant's Profession: _____ Applicant's Start Date: _____

Does Applicant speak another language at work in addition to English? If so, which language(s):

(Languages must be spoken in patient care interactions without the use of a translator.)

Total Weekly Work Hours Providing Direct Patient Care (Must be at least 32 hours per week): _____

Applicant's Primary Responsibilities or Job Functions:

To be Signed by your Direct Supervisor or Authorized Administrative Officer

1. I understand that, should the applicant be awarded, I agree to sign reports verifying that this employee is providing direct patient/client 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.

Direct Supervisor / Administrative Officer Printed Name

Email

Direct Supervisor / Administrative Officer Signature

Date

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