

WASHINGTON STATE HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM
Quarterly Service Verification Form

Form is due in our office within 14 days after the end of the quarter. In January and July of each year you must submit monthly lender payment history. Form must be signed and dated on or after the last day of the quarter (Mar 31st, Jun 30th, Sept 30th, and Dec 31st). Form must be faxed or mailed by administrator of site – not the participant.

See Instruction Sheet For Details On How To Complete This Form

PART A – TO BE COMPLETED BY RECIPIENT *(If you work at multiple sites, submit a separate form for each site)*

Year: 2011 Service Quarter: Jan-Mar Apr-Jun Jul-Sep Oct-Dec

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ Email: _____

Name of Facility: _____ Contact Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I certify that:
 I am serving as a health professional at the site listed above: I have fully applied funds received from the previous quarter to my educational debt (funds must be applied within 30 days of receipt and no later than the end of the quarter):

➤ **Signature:** _____ **Date:** _____

PART B – TO BE COMPLETED BY THE AUTHORIZED PERSONNEL OF THE FACILITY

I have reviewed the hours worked and certify that the participant listed above *(check all that apply)*

Was employed at this site for the quarter indicated above:

Worked:

Full time – a minimum of 40 hours per week *(see instruction sheet for definition of full time).*

Less than full time but a minimum of 24 hours per week. **Actual hours worked this quarter.** *(Include all paid hours – but do not include on-call or overtime hours) (Must not spend more than 4 hours per week performing practice related administrative duties) (for those participants who began their contract prior to July 1, 2009 they may work a minimum of 20 hours per week if it was pre-approved):*

Is/was on extended leave from _____ to _____ due to _____
(please indicate the reason for the extended leave)

The certifications and information provided above are true, accurate and complete to the best of my knowledge and belief.

➤ **Signature:** _____ **Date:** _____
(Must be signed by authorized personnel) (Sign and date after provider has signed/dated Part A above.)

➤ **Printed Name:** _____ **Title:** _____

PART C – PROGRAM INFORMATION

Mail to: Health Professional Loan Repayment Program
 Higher Education Coordinating Board
 PO Box 43430 Olympia WA 98504-3430

Or fax to: (360) 704-6242
Phone: (360) 596-4817
Email: chrismw@hecw.wa.gov

- Allow 14-20 business days to process payment. Form is due within 14 days from the end of the quarter.
- Forms received more than 30 days after the end of the quarter may be subject to further delay in processing.
- All funds are to be applied to the approved educational lender(s) as identified in your Award Notification.

***REMEMBER: If you are receiving your payments by EFT – it is your responsibility to contact the Office of Financial Management (OFM) to update any changes to your address, name or bank account information. Our office cannot make those changes for you.**
 Contact them at: (360) 664-7779 or email vendohelpdesk@ofm.wa.gov