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. Form must be faxed or mailed by administrator of site – not the participant. ***Due to heavy fax use, please check fax confirmation or send a follow-up email to confirm receipt.***

See Instruction Sheet For Details On How To Complete This Form

Do not leave blanks – form must be completely filled in. Please print clearly.

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

Year: 2013	☐ Jan-Mar Submit payment history	☐ Apr-Jun	☐ Jul-Sep Submit payment history	☐ Oct-Dec

Name:	Phone:
Address:	City:
State: Zip:	Email:

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):*

☐ *I have no remaining eligible loan debt; my loans are paid in full. I realize that my payments will cease but I am not released from my remaining service obligation.*

☐ *This is my final service form – total hours worked for this quarter to complete obligation must be entered in the "Actual paid hours" area below- if form is submitted before last day of quarter*

➢ **Signature:** ➢ **Date** *(on or after last day of quarter)***:**

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

Facility is required to retain the original copy of this completed form. Please fill in all blanks.

Name of Facility**:**	Supervisor's Name:

Address: City: State: Zip:

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 and **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 paid hours** worked this quarter: ☐
Include all paid hours – but do not include on-call or overtime hour. Do not include more than 4 hours per week of practice related administrative duties.

☐ Is/was on extended leave from _____ to _____ Reason: _____.

* Leave was ☐ Paid Leave ☐ Unpaid Leave *Participant may receive service credit for up to 35 days of paid leave during the calendar year. They will not receive credit for unpaid leave or leave beyond the 35 day limi . For FMLA participant will be placed on a deferment after the 35 day limit.*

☐ **FINAL FORM** – submitting hours for less than a full quarter. Actual hours worked: ☐

The certifications and information provided above are true, accurate and complete to the best of my knowledge and belief. I have read and understand the information provided on the Instruction Sheet.

➢ **Signature:** ➢ **Date***(on or after last day of quarter)***:**

Printed Name:	Title:
Phone Number:	Email:

PART C – PROGRAM INFORMATION (Fax form to 360-704-6242)

Washington Student Achievement Council Health Professional Loan Repayment Program

Fax to: (360) 704-6242 **Phone**: (360) 596-4817 PO Box 43430 Olympia WA 98504-3430 **Email**: chrisw@wsac.wa.gov

* Allow 14-20 business days to process payment. * 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 FOR PAYMENT: 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 vendorhelpdesk@ofm.wa.gov

Revised 3/13