WASHINGTON STATE HEALTH PROFESSIONAL

LOAN REPAYMENT PROGRAM

Quarterly Service Verification Form

Form is due in our office no later than 14 days after the end of the quarter. In January and July of each year you must also submit monthly lender payment history. Service Verification 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. *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: 2012	Jan-Mar (Submit payment history)	☐ Apr-Jun	☐ Jul-Sep (Submit payment history)	☐ Oct-Dec

Name		Phone	
Address	City	State	Zip

I certify that: Email

- ☐ *I am serving as a health professional at the Facility listed in Part B*
- ☐ *I have fully applied funds received from the previous quarter to my educational debt*
- ☐ *I have no remaining eligible loan debt: my loans are paid in full. I understand 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:

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

Facility is required to retain the original copy of this completed form.

Name of Facility		Supervisor Name	
Address	City	State	Zip

I have reviewed the hours worked and certify that the participant named above (check ALL that apply):

☐ Was employed at this facility 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. Participant will not receive credit for unpaid leave or leave beyond the 35 day limit. For FMLA, participant may request a deferment after the 35 day limit by contacting program staff.*

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

➢ Signature ➢ Date

Printed Name	Title
Phone Number	Email

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

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

Fax to: (360) 704-6242
Phone: (360) 596-4817
Email: chrisw@hecb.wa.gov

* Allow 14-20 business days to process payment. * Forms received more than 30 days after the end of the quarter may be further delayed in processing. * All funds must be applied to the approved educational lender(s) identified in your Award Notification within 30 days of receipt.

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 OFM at: (360) 664-7779 or email ***vendorhelpdesk@ofm.wa.gov***

Revised March 2012