WASHINGTON STUDENT ACHIEVEMENT COUNCIL
EDUCATION · OPPORTUNITY · RESULTS

WASHINGTON STATE HEALTH PROFESSIONAL

SCHOLARSHIP PROGRAM

Quarterly Service Confirmation Form – FACULTY

Do not leave blanks. Submit form **on or after** last day of quarter.

SCHOLARSHIP RECIPIENT

2015 Quarter: ☐ Jan–Mar ☐ Apr–Jun ☐ Jul-Sep ☐ Oct-Dec

Name:

Address:

City: **State:** **Zip**

Email:

I certify that: I am teaching undergraduate nursing at an educational institution in the state of Washington that meets program requirements as described on the Washington Health Professional Shortage Areas Listing and on the Promissory Note I signed.

Signature:_____
Date:

DEFINITION OF
"FULL TIME EMPLOYMENT"

At least 32 hours of the minimum 40 hours per week are/will be spent providing direct teaching related services. The remaining 8 hours per week may be spent performing administrative activities.

For part time, at least 20 hours of the minimum 24 hours per week are/will be spent providing direct teaching related services. The remaining four hours per week may be spent performing administrative activities.

All** program service quarters must meet the minimum 24 hours per week requirement – year round.* ***If not teaching in any school quarter/semester you must submit hours from work in a clinical position. Non-service periods are not allowed.

PROGRAM INFORMATION

- If this is a new employer you must submit a job description.
- Form is due in our office no later than 14 days after the end of the quarter.
- Employer must retain the original copy of the form.
- See Instructions on how to complete this form.

EMPLOYER SECTION

Site Name:

Address:

City: **Zip:**

I have reviewed the hours worked and certify that the scholarship recipient: *(check all that apply):*

Was employed at this facility for the quarter indicated and **WORKED:**

☐ **Full time** - a minimum of 40 hours per week teaching undergraduate nursing

☐ **Less than 40 hours per week, but a minimum of 24** hours per week teaching undergraduate nursing.

☐ **Actual hours worked this quarter.**

Include all paid hours – do not include overtime hours) Also use this box to fill in hours if submitting as the final form before the end of the quarter or if participant was on extended leave.

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

Paid Leave Hours: ____ Unpaid Leave Hours: ____

I have read and understand the "Instructions" on completing this form and certify that this facility meets the requirements of the program and the above recipient is working in an eligible position.

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 definition of "full time" employment

Signature:

Printed Name:

Title:

Date:

Phone Number:

Email:

Facility administrator (not the recipient) may mail, fax, or scan and email the service form to:

Mail: Washington Student Achievement Council **Fax:** 360- 704-6242
PO Box 4340 Olympia WA 98504-3430 **Email:** chrisw@wsac.wa.gov **Phone:** 360-753-7794