Washington State Health Professional Loan Repayment Quarterly Service Verification Form

Do not leave blanks. Form cannot be submit prior to last day of the quarter.

LOAN REPAYMENT RECIPIENT

2016 Quarter: ☐ Jan–Mar ☐ Apr–Jun ☐ Jul-Sep ☐ Oct-Dec

Name:

Address:

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

Email:

Phone Number:

Definition of full-time employment:

For all health professionals, at least 32 of the minimum 40 hours per week are spent providing direct outpatient care during normally scheduled clinic hours at an approved and eligible site. The remaining eight hours are spent providing clinical services to patients, performing clinical support activities in alternate locations as directed by the site(s), or performing practice-related administrative activities**.** Federal-State Loan Repayment recipients are required to work full time (two-year contract).

For part-time, at least 20 of the minimum 24 hours per week are spent providing direct outpatient care during normally scheduled clinic hours at an approved and eligible site as described above for full-time employment**.** Health Professional Loan Repayment recipients are allowed to work less than full time (minimum three-year contract).

Maximum leave days per contract year (July 1–June 30):

Participants with a Federal (FSLRP) contract are allowed a maximum of 7.14 weeks or 35.7 days per contract year away from the clinic for any reason including: vacation, sick, holiday, continuing education, or any other reason except documented FMLA.

Participants with a State (HPLRP) contract are allowed a maximum of 40 days per contract year away from the clinic for any reason including: vacation, sick, holiday, continuing education, or any other reason except documented FMLA.

Exceeding leave limits will place your contract in default.

I certify I am serving at the site listed on the right, and I have fully applied funds received from the previous quarter to my approved lender(s).

Signature:_____

Date:_____

☐ My remaining debt is less than my normal payment. Adjust this payment to the payoff amount: $ _____

☐ 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.

It is your responsibility to contact the Department of Enterprise Services (DES) to update any changes to address, name, or bank account information. Our office cannot make those changes for you. Contact DES by phone at 360-407-8180, or by email at payeehelpdesk@des.wa.gov.

EMPLOYER SECTION

Site Name:

Address:

City: | **Zip:**

I have reviewed the hours worked and certify that the loan repayment recipient named on the left side of this form was employed at this site for the quarter indicated and certify that they worked:

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

☐ **Less than 40 hours per week**, but a minimum of 24 hours per week. Fill in actual hours below.

Actual hours worked this quarter: _____

Include all **paid** hours, except **do not** include on-call or overtime hours.

If applicable, fill in hours participant was on extended leave:

☐ Employee is/was on extended leave from _____ to _____ due to (indicate the reason for the extended leave, and record paid hours worked in the Actual Hours Worked box above):
Reason: _____

Paid Leave Hours: ____ Unpaid Leave Hours: ____

Days away from the clinic (includes sick, vacation, holiday, continuing education and any other) since July 1, 2016: _____
See left column for maximum number of days allowed.
FMLA recipients must arrange for a deferment and contract addendum by contacting program staff.

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. I understand that I must retain the original copy of this form.

Employer Signature:

Printed Name:

Title:

Date:

Phone Number:

Email:

In January and July of each year, the recipient must submit payment history documentation. Be sure recipient's name, lender name, and account information is on each page. Allow 14- 20 business days for payment to be processed.

The administrator (not the recipient) may mail, fax, or scan and email this form to the Washington Student Achievement Council at:
Mail: PO Box 43430, Olympia WA 98504-3430 • **Fax:** 360-704-6242 • E**mail:** health@wsac.wa.gov • **Phone:** 360-753-7794