Washington State Health Professional Loan Repayment Quarterly Service Verification Form

Do not leave blanks. Form cannot be signed, dated, or submitted prior to last day of the quarter.
SEE INSTRUCTIONS FOR FULL DETAILS ON COMPLETING THIS FORM.

LOAN REPAYMENT RECIPIENT SECTION	EMPLOYER SECTION
If you have had a change of address, phone number or email, contact program staff.	*If there has been a change in recipient's employment site, contact program staff. (Must have prior approval.)*
Check the quarter completed: ☐ Jan – Mar 2017 ☐ Apr – Jun 2017 ☐ Jul – Sep 2017 ☒ Oct – Dec 2017	
Recipient Name:	**Site Name:**
Submit a separate form for each physical site/location.	**Site Address:**
☐ I met the minimum hours requirement per my discipline. (See Instruction Sheet for details.)	☐ Check this box if recipient was on Medical, FMLA, or other leave that may qualify for suspension. (See Suspension Form for details.) **Dates of leave:** _____ **to** _____ Recipient must download, complete and submit the Suspension Request Form
Maximum leave days per contract year (July 1–June 30): Recipients with a federal-state contract (FSLRP) are allowed a **maximum of 35.7** days (7.14 weeks) per contract year away from the site. HPLRP recipients are allowed a **maximum of 40** days per contract year. Reasons for these days away include but are not limited to: vacation, sick, holiday, continuing education, and other leave. Recipients who will exceed the maximum leave days per contract year must request a suspension in advance of the leave. If approved, the recipient's contract end date will be extended. Examples of approved suspensions are medical leave, FMLA, or call to active duty. **Exceeding days away from site without an approved suspension will be considered default.**	_____ **Actual hours worked this quarter at this site:** • Exclude hours of dates of leave listed above. • Exclude leave hours listed below.
	Total number of hours this quarter away from this site: **Paid Leave hours:** _____ **Unpaid leave hours:** _____ • Include sick, vacation, holiday, continuing education, and any other leave. • Exclude days being submitted for suspension above.
By signing, I certify that I am serving at the site listed on the right and I met the full-time and/or part-time minimum hours requirement as detailed in my contract. **Recipient Signature:**	**By signing, I certify that the information provided above is true, accurate, and complete to the best of my knowledge and belief. I have read and understand the minimum hours and days away requirements.** **Employer Signature:**
Date:	**Printed Name:**
Note: If your remaining loan debt is less than the scheduled quarterly payment, contact program staff to arrange for an adjusted final quarterly payment amount. Any over-payments must be repaid to the program.	**Title:** **Date:** **Phone:** **Email:**
Allow 14-20 business days for payment to be processed.	Site must retain original copy of this form.

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

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:** 1-866-381-1094 • **Email:** health@wsac.wa.gov • **Phone:** 1-888-535-0747

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