Washington State Health Professional Scholarship Program
Quarterly Service Confirmation Form

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

SCHOLARSHIP RECIPIENT

2017 Quarter: ☐ Jan–Mar ☐ Apr–Jun ☐ Jul-Sep ☐ Oct-Dec

Name:

Address:

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

Email:

Best Phone Number:

I certify that I am providing primary care at an eligible facility 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:

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 facility as described on the Washington Health Professional Shortage Areas Listing. The remaining eight hours are spent performing clinical support activities in alternate locations as directed by the facility(s), or performing practice-related administrative activities.

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 facility as described above for full-time employment.

Program Information:

- See instructions posted on the website on how to complete this form.
- Form is due to WSAC no later than 14 days after the end of the quarter.
- Employer must retain original copy of form.
- If this is a new employer, you must also submit a job description.

Form Submittal:

Facility administrator (not the recipient) may mail, fax, or scan and email a copy of the service form.

Mail: Washington Student Achievement Council
Health Scholarship
PO Box 43430
Olympia WA 98504-3430
Email: health@wsac.wa.gov
Fax: 360-704-6242 **Phone:** 360-753-7794

EMPLOYER SECTION

Facility Name:

Address:

City: **Zip:**

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

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

☐ **Less than full time**
but a minimum of 24 hours per week

☐ **Actual paid hours this quarter (include paid leave).**
Do not include overtime or on-call hours. Also use this box to fill in hours if submitting as the final form before the end of the quarter or if recipient was on extended leave.

☐ Employee was on extended leave
(if applicable: FMLA, medical, etc.)

From: _____ to _____
Reason: _____
Paid leave hours: _____ Unpaid leave hours: _____

I have read and understand the instructions for completing this form. I certify that this facility meets the requirements of the program, and the recipient is working in an eligible position.

The certifications and information provided above are true, accurate, and complete to the best of my knowledge. I have read and understand the definition of full time employment.

Employer Signature:

Printed Name:

Title:

Date:

Phone Number:

Email: