Washington Health Corps
Quarterly Service Verification Form

Do not leave blanks. Form cannot be signed, dated or submitted prior to the last day of the quarter. Separate forms must be submitted for each physical site/location.

Participant Section

Participant Name ____

Site Name ____

Site Street Address ____

Site City, State & Zip ____

☐ **I have met the minimum hours requirement per my discipline.**

Check the quarter completed: ☐ Jul-Sep ☐ Oct-Dec ☐ Jan-Mar ☐ Apr-Jun

By signing, I certify I met the minimum hours requirement as detailed in my contract, at the site listed above.

Participant Signature ________________________________ **Date** ____________

Employer Section

☐ Check this box if participant was on Medical, FMLA, or other leave that may qualify for deferment. (See deferment form for details – participant must complete and submit the form.)

If box above is checked, list dates of leave: ☐ to ☐

ACTUAL HOURS WORKED this quarter, at this site: ☐

- Exclude hours of dates of leave, if listed above.
- Exclude paid leave hours, listed below.

PAID LEAVE HOURS away from this site, this quarter: ☐

By signing, I have read and understand the minimum hours and days away requirement for the above participant and certify the information provided is accurate and true. I also understand the site must retain the original form and give a copy to the participant.

Employer Signature ________________________________ **Date** ____________

Printed Name ____

Title ____

The employer (not the participant) may scan and email this form to:
• **Email:** health@wsac.wa.gov • **Phone:**1-888-535-0747, Opt 5.