



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			EMPLOYER SECTION	
2017 Quarter: <input type="checkbox"/> Jan-Mar <input type="checkbox"/> Apr-Jun <input type="checkbox"/> Jul-Sep <input type="checkbox"/> Oct-Dec			Facility Name:	
Name:			Address:	
Address:			City:	Zip:
City:	State:	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: <input type="checkbox"/> Full time a minimum of 40 hours per week <input type="checkbox"/> Less than full time but a minimum of 24 hours per week	
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:	<input style="width: 50px; height: 20px;" type="text"/> 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.	
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.			<input type="checkbox"/> Employee was on extended leave (if applicable: FMLA, medical, etc.) From: _____ to _____ Reason: _____ Paid leave hours: _____ Unpaid leave hours: _____	
Program Information: <ul style="list-style-type: none"> 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. 			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.	
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 Signature: _____ Printed Name: _____ Title: _____ Date: _____ Phone Number: _____ Email: _____	