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: _____

COVID-19 RELATED HOURS away from this site, this quarter: _____

(Please only list COVID-19 hours that should **not** count as Hours Worked or Hours Away. Please see COVID-19 FAQs on our website or contact us for more information.)

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 fax or scan and email this form to:
Fax:1-866-381-1094 • **Email:** health@wsac.wa.gov • **Phone**:1-888-535-0747, Opt 5.