

# 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 scan and email this form to:  
**Email:** [health@wsac.wa.gov](mailto:health@wsac.wa.gov) • **Phone:** 1-888-535-0747, Opt 5.