

## WASHINGTON STATE HEALTH PROFESSIONAL SCHOLARSHIP SERVICE CONFIRMATION FORM – FACULTY

- Please return completed form to our office within 14 days after the end of the quarter.
- Form must be fully completed – do not leave blanks. Incomplete form will be returned.
- Form must be signed and dated on or after the last day of the quarter. (Mar 31<sup>st</sup>, Jun 30<sup>th</sup>, Sept 30<sup>th</sup>, and Dec 31<sup>st</sup>.)

*Please print clearly.*

<b>PART A – TO BE COMPLETED BY RECIPIENT (Numbers 1 –8 Required)</b>	
1. Service Quarter 2009: <input type="checkbox"/> Jan-Mar <input type="checkbox"/> Apr-Jun <input type="checkbox"/> Jul-Sep <input type="checkbox"/> Oct-Dec	2. Phone #:
3. Name:	Email Address:
Address:	
<input type="checkbox"/> Check here if new address, phone number or name change.	
4. Select one of the following:	
<input type="checkbox"/> A. Initial Employment after completing academic program.	Start date: _____ (attach job description)
<input type="checkbox"/> B. Change in employment. (attach job description) Start Date: _____ Last day at previous employer: _____	
<input type="checkbox"/> C. Employer same as previously reported. (Name is listed below in Part B)	
5. Faculty Hours worked per week: <input style="width: 50px;" type="text"/> Total Faculty Actual Hours worked this quarter (required): <input style="width: 50px;" type="text"/> <b>Do not include overtime or on-call hours. Maximum of 480 service credit hours per quarter. The required minimum is 240 service credit hours per quarter.</b>	
6. Clinical Hours worked per week: <input style="width: 50px;" type="text"/> Total Clinical Actual Hours worked this quarter (required): <input style="width: 50px;" type="text"/> <b>Maximum of 480 service credit hours per quarter – required minimum is 240 service credit hours per quarter.</b>	
<i>I certify that I am teaching a minimum of 24 hours per week in undergraduate nursing in an area that is experiencing a critical shortage of qualified nursing faculty.</i>	
7. Signature: _____	8. Date: _____
PART B – TO BE COMPLETED BY EDUCATIONAL FACILITY	
1. Education Facility Name:	2. Phone:
3. Address:	
4. I certify under penalty of perjury that the information stated above is true and correct. The person named above <input type="checkbox"/> IS or <input type="checkbox"/> WAS (indicate one) working at the above facility and is eligible for the above period in partial fulfillment of the recipient's Health Professional Scholarship obligation.	
5. Signature: _____	6. Date: _____
<i>Do not sign and date unless participant has completed Part A: 1-8 and signed/dated document prior to your signature.</i>	
7. Printed Name: _____	8. Title: _____
PART C – TO BE COMPLETED BY CLINICAL SITE	
1. Facility Name:	2. Phone:
3. Address:	
4. I certify under penalty of perjury that the information stated above is true and correct. The person named above <input type="checkbox"/> IS or <input type="checkbox"/> WAS (indicate one) working at the above facility and is eligible for the above period in partial fulfillment of the recipient's Health Professional Scholarship obligation.	
5. Signature: _____	6. Date: _____
<i>Do not sign and date unless participant has completed Part A: 1-8 and signed/dated document prior to your signature.</i>	
7. Printed Name: _____	8. Title: _____
PART D – PROGRAM INFORMATION	
Service Confirmation Forms are due 15 days after the end of the quarter.. Forms can be mailed or faxed (not both). Fax Number: 360-704-6242 Email: chrisw@hecb.wa.gov Office Number: 360-596-4817 Mailing address: Health Professional Scholarship Program PO Box 43430 Olympia, WA 98504-3430 <b>It is your responsibility to inform our office of any change in employment status, name or address.</b>	