

WASHINGTON STATE HEALTH PROFESSIONAL SCHOLARSHIP QUARTERLY SERVICE CONFIRMATION FORM

- 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 31st, Jun 30th, Sept 30th, and Dec 31st.)

Please print clearly.

PART A – TO BE COMPLETED BY RECIPIENT (Numbers 1 –8 Required)

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 #:
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3. Name:	Email Address:
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Address:

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: _____ <i>(attach job description)</i>
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<input type="checkbox"/> B. Change in employment. <i>(attach job description)</i> Start Date: _____	Last day at previous employer: _____
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C. Employer same as previously reported.

5. Hours worked per week: 6. Total Actual Hours worked this quarter *(required)*: *Include all paid hours except – do not include on-call or overtime hours. Maximum of 480 service credit hours per quarter – required minimum is 240 service credit hours per quarter.*

- PLEASE NOTE:**
- Emergency Department, Urgent Care Clinics, Specialty Clinics and Placement Agencies do not qualify for service obligation credit. (Nurses may work in ED with prior approval.)
 - Participant must comply with program Designated Shortage Criteria. *Service credit will be prorated for less than 40 hours per week.*

I certify that I am providing primary care and serving in a designated shortage area in the state of Washington.

7. Signature: _____	8. Date: _____
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PART B – TO BE COMPLETED BY EMPLOYER (Numbers 1-8 required)

1. Facility Name:	2. Phone:
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3. Address:

4. *I certify under penalty of perjury that the information stated above is true and correct. The person named above*
 IS or *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: _____
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Do not sign and date unless participant has completed Part A: 1-8 and signed/dated document prior to your signature.

7. Printed Name:	8. Title:
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PART C – PROGRAM INFORMATION

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

It is your responsibility to inform our office of any change in employment status, name or address.