Rhode Island Health Professional Loan Repayment Program
Employment Verification Form (EVF)

This form is to be completed for each practice site the health professional provides direct patient care and should pertain to their work only at that site.

The below portion must be completed by Health Professional

Health Professional's First and Last Name: ____

This authorization is to release information concerning my employment as required below. To establish eligibility for the Rhode Island Health Professional Loan Repayment Program, verification of employment is required. Your cooperation and prompt return of this information is appreciated.

________________________________ Signature of Health Professional

________________ Date

The below portions must be completed by the health professional's direct supervisor or an appropriate designee from human resources at the HPLRP-approved service site. (All questions are required)

Practice Site Name:	
Practice Site Telephone #:	
Practice Site Address: **(Address of the practice site where the applicant works)**	Street Address: City: State: Zip Code: County:

EVF Reporting Period: through

Enter the health professional's average number of direct patient care hours per week during the EVF Reporting Period listed above. **(Direct Patient Care includes clinical services provided and activities in which a provider participates that have a direct influence on the care of a patient or client, such as examinations, treatments, counseling, patient education, self-care training, and the administration of medications.)**	________ (Direct patient care hours)
Enter the health professional's average number of administrative hours per week during the EVF Reporting Period listed above. **(Administrative work includes any clinic-related work not described above.)**	________ (Administrative hours)
Enter the health professional's average number of total hours worked per week during the EVF Reporting Period listed above. **(Total of average Direct Patient Care hours per week and average Administrative hours per week.)**	________ (Total hours)
Enter the health professional's total number days missed during the EVF Reporting Period listed above. **(Do not include regular days off.)**	________ (Missed days)

I certify that I am knowledgeable about the health professional's employment schedule.
I declare under penalty of perjury that these statements are true and correct in all material respects.

________________________________ Signature of Direct Supervisor or Human Resources Representative

________________ Date

________________________________ Printed First and Last Name

________________ Email

Revised 11/09/2022