KANSAS STATE LOAN REPAYMENT PROGRAM

Health Care Professional Employment Verification

For more information: http//www.kdheks.gov/olrh/FundLoan.html
Email questions to: kdhe.primarycare@ks.gov

Health Care Professional Name: _____ Discipline: _____

Health Care Practice Site: _____

This form must be completed at the end of each State Loan Repayment Program (SLRP) contract year by an authorized representative of the health care practice site for the SLRP participant.

☐ Yes ☐ No The health care professional has worked full-time at this practice site a minimum of 40 hours per week, 45 weeks per year, in no less than four days per week, with no less than 32 hours per week spent providing direct patient care for the entire Contract year.

Hours worked per week: _____ Hours spent providing direct patient care per week: _____

Report the number of days or partial days the SLRP recipient was away from the health care practice site for the reporting time frame. Total hours away from practice site should not exceed 35 days (280 hours).

Report hours in partial hour increments shown below:

2 hours = .25 day
4 hours = .5 day
6 hours = .75 day
8 hours = 1 day

SLRP Contract Reporting Period: _____ to _____

MONTH	YEAR	VACATION HOURS	SICK HOURS	HOLIDAY HOURS (Include hours clinic closed)	CONTINUING EDUCATION HOURS	OTHER (Explain)
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
TOTAL HOURS						

See next page for signature block.

I certify that the information provided is accurate and complete to the best of my knowledge.

_____ _____

Printed Name of Authorized Practice Site Representative Date

_____

Signature of Authorized Practice Site Representative

Submit all documents to:

State Loan Repayment Program
Office of Primary Care & Rural Health
Bureau of Community Health Systems
1000 SW Jackson St, Suite 340
Topeka KS 66612-1365
Phone: 785-296-3135