Department of Health Care Access and Information

County Medical Services Program Loan Repayment Program (CMSP LRP)
Employment Verification Form

Program Participant and Grant Number:	
Dates of Service:	
Employer Site Name:	
Employer Site Representative's Name:	

Number of hours per week spent *working* at site:	
Number of hours per week spent *providing direct patient care* at site:	
Number of hours per week spent providing direct patient care in other settings (e.g., hospital)	
Number of hours per week spent on *providing other administrative or related duties*:	
Number of days provider missed during this period of time (*do not* count regular days off):	

I am the Site Representative named above, and I am knowledgeable about the program participant's employment schedule during the service period listed. For the service period listed, the program participant has provided **full-time/ half-time/ extension** "direct patient care" at the site(s) named above. **"Direct patient care"** means the provision of health care services directly to individuals treated for having a physical or mental illness or condition, including preventative care.

1. "Full time Service" means:

- **Providers of primary medical health care services, dentists, nurse practitioners, physician assistants, pharmacists and registered dental hygienists:** Clinician works a minimum of 40 hours per week, for a minimum of 45 weeks per service year. The 40 hours per week may be compressed into no less than four (4) days per week, with no more than 12 hours of work to be performed in any 24 hour-period. Of the 40 hours per week, a minimum of 32 hours must be spent providing direct patient care, in an outpatient setting. No more than eight (8) hours per week can be spent in administrative capacity or practice-related activities.
- **Providers of obstetrics/gynecology (including family medicine physicians who practice obstetrics on a regular basis and certified nurse midwives), and mental and behavioral healthcare providers**: Clinician works a minimum of 40 hours per week, for a minimum of 45 weeks per service year. At least 21 hours per week must be spent providing direct patient care, in an outpatient setting, at the approved service site(s). The remaining 19 hours per week can be spent providing inpatient care in an approved clinical setting (i.e., hospitals, shelters) as directed by the approved site(s), or performing practice-related administrative activities. No more than eight (8) hours per week can be spent in an administrative capacity or be spent performing practice-related activities.
- The time spent "on-call" cannot be counted toward the 40-hour week.

2. "Half-time Service" means:

- **Providers of primary medical health care services, dentists, nurse practitioners, physician assistants, pharmacists and registered dental hygienists:** Clinician works a minimum of 20 hours per week, for a minimum of 45 weeks per service year. Of the 20 hours per week, a minimum of 16 hours must be spent providing direct patient care, in an outpatient setting. No more than four (4) hours per week can be spent in an administrative capacity or be spent performing practice-related activities.
- **Providers of obstetrics/gynecology (including family medicine physicians who practice obstetrics on a regular basis and certified nurse midwives), and mental and behavioral healthcare providers**: Clinician works a minimum of 20 hours per week, for a minimum of 45 weeks per service year. At least 11 hours per week must be spent providing direct patient care, in an outpatient setting, at the approved service site(s). The remaining nine (9) hours per week can be spent providing inpatient care in an approved clinical setting (i.e., hospitals, shelters) as directed by the approved site(s), or performing practice-related administrative activities. No more than four (4) hours per week can be spent in an administrative capacity or spent performing practice-related activities.
- Time spent "on-call" cannot be counted toward the 20-hour week.

3. I declare under penalty of perjury that these statements are true and correct.

Print Name: _____

Signature: _____ **Date:** _____

Telephone Number: ( )_____

E-mail Address: _____