HEALTH PROFESSIONS EDUCATION FOUNDATION

HEALTH PROFESSIONS EDUCATION FOUNDATION (HPEF)
EMPLOYMENT VERIFICATION FORM (EVF)

Instructions

1. Applicant **must** complete **all** fields under Employment Certification.
2. This form **will not** be considered complete without **all** required signatures.

Applicant name:_____

This authorization is to release information concerning my employment as required below. To establish eligibility for the Health Professions Education Foundation Programs, verification of employment (including completion of all fields below) is required. Only official HPEF Employment Verification Forms (EVF) will be accepted.

Applicant signature:_____ Date:_____

EMPLOYMENT CERTIFICATION

Employer name:_____

Employer address (**where physically work**):_____

City:_____ State:_____ Zip:_____ County:_____

Profession:_____ Title: _____

Start Date:_____

Primarily serves adults over the age of 65 years or adults with disabilities: ◯ **Yes** ◯ **No**

Total weekly hours providing Direct Patient Care (DPC)(**required 32+ hours per week**):_____

Speak another language at work in addition to English? If so, which language(s):_____

Primary responsibilities or job functions:

1. *I understand that, should the applicant be awarded, I agree to sign reports verifying that this employee is providing direct patient care until the service obligation is complete.*
2. *I declare under penalty of perjury that the information contained in this form is true and correct to the best of my knowledge.*

_____ _____
Direct Supervisor / Administrative Officer Printed Name Email

_____ _____
Direct Supervisor / Administrative Officer Signature Date

Applicant: Upload this form and input the information provided above https://eapp.oshpd.ca.gov/funding/.