LICENSED MENTAL HEALTH SERVICES PROVIDER EDUCATION PROGRAM (LMH)
EMPLOYMENT VERIFICATION FORM (EVF)

Directions at Time of Application

1. Applicant **must** complete **all** fields in Section A (General Information) and Section B (Employment Certification).
2. Upon completion of Section A and B, Applicant **must** obtain the signature of Direct Supervisor or Authorized Administrative Officer in Section B.
3. Once both Section A and B have been completed and signed, Applicant must upload completed form into eApp by the application deadline.

Directions if Awarded

1. Awardee will need to complete steps 1 through 3 (above) anytime their employer changes.

A. GENERAL INFORMATION

Applicant's Name:______________________________

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

Applicant's Signature:______________________ Date:______________

The Applicant's Employer or Volunteer Agency/Facility is designated as:

- Non-profit Mental Health Facility that Contracts with a County Entity
- Publicly Funded Mental Health Facility
- Health Professional Shortage Area - Mental Health (HPSA-MH)
- Public Mental Health Facility

Employment or Volunteer Agency/Facility Name:______________________________

Employment or Volunteer Agency/Facility Address:______________________________

(Note: Please enter the address of the employer or agency/facility the applicant is currently working at, and not the administrative/headquarters office.)

City:______________ Zip:__________ County:______________

B. EMPLOYMENT CERTIFICATION

Applicant's Profession:______________ Applicant's Job Title:______________

Applicant's Start Date:______________

Does Applicant speak another language at work in addition to English? If so, which language(s):

____

(Languages must be spoken in client care interactions without the use of a translator.)

Total Weekly Work or Internship Hours Providing Direct Client Care **(Must be at least 32 hours per week)**:__________

Applicant's Primary Responsibilities or Job Functions:

To be Signed by your Direct Supervisor or Authorized Administrative Officer

1. *I understand that, should the applicant be awarded, I agree to sign reports verifying that this employee is providing direct patient/client 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/.