

Kansas Department of Health & Environment  
Bureau of Community Health Systems

**Verification of Employment**  
**Kansas State Loan Repayment Program**

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This form is used to verify employment of the health professional. The form is to be completed by the authorized site official.

Name of Health Professional \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Practice Site \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hours per week at site \_\_\_\_\_

Practice Site \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hours per week at site \_\_\_\_\_

Practice Site \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hours per week at site \_\_\_\_\_

I certify that the above named provider began/will begin work at the above-named site on \_\_\_\_\_.

I certify that the above named provider works/will work full-time (at least 40 hours per week) for at least 45 weeks per year. At least 32 of the minimum 40 hours per week are/will be spent providing direct patient care (21 for OB/GYN physicians, nurse midwives and behavioral and mental health providers).

\_\_\_\_\_  
Printed Name of Authorized Site Representative

\_\_\_\_\_  
Title of Authorized Site Representative

\_\_\_\_\_  
Signature of Authorized Site Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email