

# Employment Verification Form

## Nurse Retention Loan Repayment Program

### PART I – TO BE COMPLETED BY THE APPLICANT (COMPLETE IN INK)

#### PERSONAL INFORMATION:

Last Name	First Name	Last Four of SSN (XXXX)
Home Address (Street Address/PO Box, City, State, Zip)		
Contact Phone #	Date of Birth (MM/DD/YYYY)	Email Address

#### LOAN INFORMATION: *The accuracy of the following information is critical. Award payment will NOT be made without COMPLETE loan information!*

Name of Loan Servicer (exactly as it appears on your account/bill/remittance form)	Loan Servicer Account Number
Loan Servicer Payment Mailing Address (Street Address/PO Box, City, State, Zip)	

#### EMPLOYMENT INFORMATION:

Name of Employer	County Where Physically Work
Position/Title	Hours/Week Worked

CERTIFICATION: I hereby certify that I AM employed as a FULL-TIME licensed practical nurse or licensed registered nurse in a Mississippi skilled nursing facility or acute general care hospital, and all information provided on this form is correct:

X \_\_\_\_\_  
Signature of Applicant Date

### PART II – TO BE COMPLETED BY EMPLOYER

**Place Official Stamp or Seal  
in Space Below**

CERTIFICATION: I hereby certify that the information provided on this form is correct:

X \_\_\_\_\_  
Signature of Authorizing Official Date

Printed Name, Title, and Address of Official	<b>Official Stamp or Seal</b> - If no stamp or seal is available, please provide <b>letterhead certification</b> , signed by an official representative of the employer <u>in addition to this form</u> . The letter must include employee's name, employment dates, total hours/week worked, and position.
Telephone #	

#### APPLICANT SERVICE INFORMATION:

Dates Applicant Employed Full-time (MM/DD/YYYY)	From:	To:
Position:	Number of Years as a Licensed Nurse *:	Year of Service in Your Employ:

\* Nurse Retention Loan Repayment is available to full-time nurses in their first, second, or third year of nursing after licensure. An applicant is considered a first-year nurse if they have not been employed as a licensed nurse in a previous state or healthcare setting.

**NOTE: This form is INCOMPLETE without applicant's signature and COMPLETE Part I and II certifications.**

#### RETURN FORM TO:

Mississippi Office of Student Financial Aid  
3825 Ridgewood Road  
Jackson, MS 39211

#### CONTACT:

Email: sfa@mississippi.edu  
Phone: 1-800-327-2980 or 601-432-6997  
Fax: 601-432-6527

PART III FOR OFFICE USE  
PROCESSED BY: \_\_\_\_\_ DATE: \_\_\_\_\_