Virginia Physician Assistant Scholarship Program
VERIFICATION OF EMPLOYMENT

I,_____ authorize my employer to provide the employment information requested by the Virginia Department of Health, Office of Health Equity (VDH-OHE.) A copy or facsimile of this authorization may be accepted as an original.

Signature of the Scholarship Recipient | Social Security Number | Date

Name of Scholarship | Year of Award | Home Address

_____ has applied for or is a participant in the Physician Assistant Scholarship Program administered by the VDH-OHE. As a participant in this program, it is required that employment certification is provided from the employer. Please complete the following section and return it to the address or fax number listed below. Thank you.

Employer: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

This Section is to be Completed by Employer

Dates of Employment: Start Date*_____ - End Date_____

*Start date must be after graduation date of program for which the nursing scholarship(s) was/were awarded

Type of Position:_____

Does the recipient work full-time each week? ☐ **Yes** ☐ **No**

Name of Certifying Official/Administrator | Title

Signature of Certifying Official/Administrator | Date

Email address of Certifying Official/Administrator

Name and address of Organization (if different from Practice Site listed above):

Remit to: Virginia Department of Health
Office of Health Equity
109 Governor Street, Suite 714 West
Richmond, VA 23219
Office 804. 864.7435 Fax 804.864.7440

Total Months: Remaining Months: Data Entry: / /20

Revised in June 2016