SERVICE VERIFICATION FORM

This is to certify that ____________________________ has completed ☐ full time or ☐ half time,
(Loan Repayment Recipient)

continuous employment in good standing with ________________________________ for the service quarter
(Approved Service Site)

beginning ______________________ and ending __________________ as specified in the Arizona Loan
(MM/DD/YY) (MM/DD/YY)
Repayment Program contract executed with the Arizona Department of Health Services.

- Telemedicine Services (if applicable)
  I certify that I have provided ____hours of telemedicine services this quarter. I certify that the originating site, _____________________ where the patient is located and the distant site, ______________________ where the provider is located, are both in a Health Professional Shortage Area (HPSA) or in a HPSA or Arizona Medically Underserved Area (AzMUA). ______Provider Initial

- Critical Access Hospital Services (if applicable)
  I certify that I have provided at least 24 hours per week of outpatient primary care services this quarter at the approved outpatient service site listed above as required per my loan repayment contract, AND ____hours in the critical access hospital, ___________________________ this quarter or at least 16 hours per week.
  ______Provider Initial

This signed and notarized form is due 10 business days after the last day of the completed quarter.

The form shall be submitted to:

Arizona State Loan Repayment Program Manager
Bureau of Women's and Children's Health
Arizona Department of Health Services
150 N. 18th Avenue, Suite 320
Phoenix, Arizona 85007

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I hereby certify that I have completed the above service quarter in accordance with the terms and conditions of my Loan Repayment Program contract. Please make payment on my educational loans as agreed upon in my contract.

____ ____________________
(Signature of Loan Recipient) Date

State of ______Arizona______)
)
County of _________________)

The foregoing instrument was acknowledged before me this ______ day of ______________ , ________
date month year

by ____________________________ My Commission Expires: __________________________
Notary Public Date

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I hereby verify that this service site and the services provided herein are in compliance with A.A.C. R9-15-202, Primary Care Provider and Service Site Requirements.

____ ____________________
Signature of Service Site Executive Director/Administrator or authorized signatory Date

State of ______Arizona______)
)
County of _________________)

The foregoing instrument was acknowledged before me this ______ day of ______________ , ________
date month year

by ____________________________ My Commission Expires: __________________________
Notary Public Date

================================ **FOR OFFICE USE ONLY** ================================

ACCOUNTING:
PLEASE PAY LENDER: ____

Contract No: ______________________ SCHEDULED PAYMENT $ ______________________

FY __________ PCA __________ Index __________ % __________

FY __________ PCA __________ Index __________ % __________

Approved for Payment by ______________________________ Date: ______________________