Maryland Loan Repayment Programs

Employment Verification Form

To be completed by participant's employer.

Participant Name: _____

Practice Site Name: _____

Practice Site Address: _____

Participant Specialty: _____

Dates of Employment: _____ - _____ Annual Salary: $_____

Please respond to the following questions regarding the time period July 1, 2024 - June 30, 2025.

1. How many hours per week has the participant worked per week (excluding time spent "on- call")?

_____

2. Has the participant provided at least 80% of time worked providing direct patient care?

☐ Yes ☐ No

3. Has the participant spent at least forty-five (45) weeks working at the practice (Less than 35 days away from the practice for holidays, vacation, continuing professional education, illness or any other reason during this period of employment? ☐ Yes ☐ No

If no, please explain and provide detail: _____

_____

_____

I certify that the information provided above is true and complete to the best of my knowledge.

Signature of Certifying Official _____ Date _____

Printed/Typed Name _____ Title _____

Email Address _____