



## Maryland Loan Repayment Programs Employment Verification Form

To be completed by the 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, 2025 - June 30, 2026.**

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's workweek been compressed into less than 4 days per week (with no more than 12 hours performed in any 24-hour period)?

Yes       No

4. 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: \_\_\_\_\_