HEALTH PROFESSIONS EDUCATION FOUNDATION
Giving Golden Opportunities

LMH

LMH Employment or Internship Verification Form

First Name: _____ Last Name: _____

Parts A. through F. are to be completed by the applicant. This page must be signed and dated by the applicant's Direct Supervisor or an Authorized Administrative Officer who can verify the applicant's information and hours.

A. **Employment or Volunteer Facility/Agency**:_____
Program Name: _____
Address:_____
City: _____ Zip: _____ Employment County:_____

B. **Applicant speaks the following language(s) needed in this work setting:**_____

C. **Applicants start date:** _____

D. **Applicant's profession:**_____

E. **Applicant's primary responsibilities or job functions:**_____

_____

_____

F. **Total weekly work or internship hours providing direct patient care:**_____ hours
(must be at least 32 hours per week)

Name of Supervisor or Authorized Administrative Officer: _____

Title:_____ Phone #:_____ Email: _____

I certify that I am the supervisor or authorized administrative officer at this facility/agency and that the facility/agency will pay the applicant (if in a paid capacity) prevailing wages and that I agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.). Descriptions of the types of qualified facilities are listed on the Health Professions Education Foundation's website at www.healthprofessions.ca.gov. **I verify that the information provided on this page of the LMH application is true and accurate to the best of my knowledge.**

Please check all that apply to your agency:

- ☐ Mental Health Professional Shortage Area
- ☐ A publicly funded facility
- ☐ A publicly funded or public mental health facility
- ☐ A non-profit private mental health facility

Direct Supervisor or Authorized Administrative Officer SIGNATURE and DATE REQUIRED!

Signature: _____ **Date:** _____