



Employment Verification Form

SECTION I: Applicant Authorization (To be completed by the applicant.)

I authorize my supervisor or a representative from the human resources department to verify that I am employed as a clinician as described below (including any additional site locations on a separate sheet).

Employer Name:			
Address:			
City:	State:	ZIP:	County:
Supervisor's Name:		Telephone Number:	

Primary Practice Site Location of Applicant

Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	
If the address is not in a HPSA, is it a rural area as defined Rule 64W-4.001(8)(d)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Secondary Practice Site Location of Applicant

Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	
If the address is not in a HPSA, is it a rural area as defined Rule 64W-4.001(8)(d)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Tertiary Practice Site Location of Applicant

Facility/Practice Name:			Weekly Direct Patient Care Hours:
Address:			
City:	State:	ZIP:	County:
Contact Name:		Contact Phone:	
HPSA Score:	HPSA Name:	HPSA ID Number:	
If the address is not in a HPSA, is it a rural area as defined Rule 64W-4.001(8)(d)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Additional site locations must be submitted on separate sheet. All location information must be included.

Applicant's Signature_____
Date_____
Applicant's Printed Name

Florida Reimbursement Assistance for Medical Education (FRAME) |

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SECTION II: Employment Verification (To be completed by supervisor or human resources department)

The applicant's first date of employment with this employer: .

Employer Type: (select one)

- | | |
|---|---|
| <input type="checkbox"/> A federally funded community health center | <input type="checkbox"/> A federally funded migrant health center |
| <input type="checkbox"/> Correctional facility | <input type="checkbox"/> County health department |
| <input type="checkbox"/> State hospital | <input type="checkbox"/> Children's Medical Services program |
| <input type="checkbox"/> Other publicly funded health care program | <input type="checkbox"/> Other non-profit health care program |
| <input type="checkbox"/> For profit business | <input type="checkbox"/> Other |

Please provide a breakdown of each payer type for the employer for the previous calendar year.

<i>Sliding Fee/ Charity Care</i>	<i>Medicaid (including dual eligible)</i>	<i>Medicare Only</i>	<i>Private Insurance/Other</i>	<i>Total</i>
%	%	%	%	100%

I certify that the above applicant is providing medical care and employed at the work sites above (including any additional site locations on a separate sheet). I further acknowledge that all information and statements contained herein are true and do not misrepresent fact and that I have not evaded or suppressed any information contained in this verification form.

Employer's Signature

Date

Employer's Printed Name

NOTICE: Any person who knowingly makes a false statement or misrepresentation on this form is subject to penalties under section 837.06, Florida Statutes, which may include fines, imprisonment, or both.