

➤ Hire date for **post-graduation**.

- Don't forget to submit your **transcript** to the ABN's Loan/Scholarship Dept. You may also email the ABN Loan/Scholarship Dept. if you have already submitted it to the ABN Advanced Practice Dept.

➤ Hire date for **employment change**.

➤ Six-month date range for **semi-annual**.

Do not submit post-dated forms.

1. Enter your identifying information.

2. Select the verification type & enter the corresponding date(s):

3. Enter your employer information.

4. Enter any additional practice sites & hours worked at each.

5. Report your site's Area of Critical Need qualification.

➤ Tools for determining an Area of Critical Need:

- "Am I Rural?"
- Primary Care HPSA Score

➤ Submit the Report with:

- Post-graduation EV
- Employment change EV

Nurses who receive funds from the ABN Loan Repayment or Scholarship Programs must verify completion of the service obligation.

6. This section is to be completed by the nurse's employer.

Upload completed EVs to [My Profile](#) by the 10th day of the month in which it is due.

7. Nurse signature

Scholarship or Loan Repayment Program Recipient		
Instructions: Complete and upload the form to My Profile .		
Name	RN License No. 1- _____	
Phone ()	Email	
Verification Type and Date		
Post-graduation employment	Employment change	Semi-annual
Hire date: / /20__	Hire date: / /20__	Date range: / /20__ to / /20__
Employer Name:		
Street Address		
City, State, Zip		
Phone ()	No. of hours worked weekly	
County		
For APN (CRNP, CRNA, CNM) Loan recipients only		
Does your practice site(s) differ from the employer address listed above? No Yes		
If yes, you must provide the following information:		
Site Name & Address	No. of hours worked weekly	
Phone ()	County:	
Site Name & Address	No. of hours worked weekly	
Phone ()	County:	
Do all of your practice sites qualify as being in an Area of Critical Need? Yes No		
ABN Administrative Code § 610-X-12.01(5)		
I have reviewed my employment site(s) using the "Am I Rural?" Tool. Yes No N/A		
To be completed by the nurse's employer		
Print name & title of person completing this form		
Email	Phone ()	
Is the nurse working at least 36 hours weekly? Yes No		
What is the role of the nurse: RN Nursing Instructor/ Educator Advanced Practice Nurse (CRNP, CRNA, CNM)		
(Choose one)		
Was the nurse on any extended leave during the reporting period? No Yes		
If yes, enter the dates of extended leave: / / 20__ to / / 20__		
Employer Signature		Date:

Signature of Scholarship or Loan Repayment Program nurse recipient affirming that the information submitted on this employment verification is true and accurate.

Signature: _____