



PSYCHIATRIC-MENTAL HEALTH NP CERTIFICATE SCHOLARSHIP PROGRAM

Verification of Employment & Accommodation Form

(Please include in the application packet.)

I, _____, authorize my employer to provide the employment information requested by the Virginia Health Care Foundation.

Scholarship Applicant Signature

Date

The individual above has applied to the Virginia Health Care Foundation's (VHCF) Psychiatric-Mental Health NP (PMHNP) Certificate Scholarship Program, which underwrites tuition and fees for participation in a PMHNP post-masters Certificate program for eligible nurse practitioners. VHCF requires verification of employment and an indication of accommodations that will be made to allow the applicant to fulfill the classroom and clinical requirements of the educational program. An indication of your intent to employ the individual in a PMHNP role post-program completion is requested, if applicable. Thank you.

Executive Director Name:

Employer:

Employer's Address:

Email:

Phone Number:

Fax Number:

Applicant's Position:

Employment Start Date:

Number of Hours/Month:

Current Annual Salary:

Please describe the accommodations that you will make in the applicant's work schedule or percent of effort during the educational program:

Do you intend or desire to employ the individual in a PMHNP role post-program completion?
Yes or No

If Yes, how many hours a week would you employ the person as a PMHNP? _____

Employer's Signature

Date