Physician Assistant Scholarship Program
VERIFICATION OF EMPLOYMENT

I,_____ authorize my employer to provide the employment information requested by the Virginia Department of Health, Office of Health Equity (VDH-OHE.) A copy or facsimile of this authorization may be accepted as an original.

Signature of the Scholarship Recipient | Social Security Number | Date

Name of Scholarship | Year of Award | Home Address

_____ has applied for or is a participant in the Physician Assistant Scholarship Program administered by the VDH-OHE. As a participant in this program, it is required that employment certification is provided from the employer. Please complete the following section and return it to the address or fax number listed below.

Employer: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

****This Section is to be Completed by Employer***

Dates of Employment: Start Date_____ - **End Date** _____

Type of Position:_____

Does the recipient work full-time each week? ☐ **Yes** ☐ **No**

If No, please explain: _____

Name of Certifying Official/Administrator | Title

Signature of Certifying Official/Administrator | Date

Email address of Certifying Official/Administrator

Name and address of Organization (if different from Practice Site listed above):

Remit to: Virginia Department of Health- Office of Health Equity
109 Governor Street, Suite 714 West, 7th Floor
Richmond, VA 23219-2448
Fax: 804.864.7440
Send routine VOEs/Correspondences to: incentiveprograms@vdh.virginia.gov

Total Months: Remaining Months: Data Entry: / /20

Revised in 1/4/2022