Florida Reimbursement Assistance for Medical Education (FRAME) |

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)? ☐ Yes ☐ 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)? ☐ Yes ☐ 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)? ☐ Yes ☐ No			

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

Applicant's Signature _____ Date _____ Applicant's Printed Name _____

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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)

- ☐ A federally funded community health center
- ☐ A federally funded migrant health center
- ☐ Correctional facility
- ☐ County health department
- ☐ State hospital
- ☐ Children's Medical Services program
- ☐ Other publicly funded health care program
- ☐ Other non-profit health care program
- ☐ For profit business
- ☐ Other

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

Sliding Fee/ Charity Care	***Medicaid (including dual eligible)***	***Medicare Only***	***Private Insurance/Other***	***Total***
%	%	%	%	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.