NFLP EMPLOYMENT CERTIFICATION FORM

[*Applicant's Name*] entered into a contractual agreement with the [***Name of Lending School***] as a participant in the Nurse Faculty Loan Program (NFLP). This program requires the borrower to be employed full-time/part-time as nurse faculty in an accredited school of nursing, or as a full-time/part-time clinical educator/preceptor at an accredited health facility, or as designation of nurse faculty in a joint nurse faculty appointment serving as full-time advanced practice registered nurse (APRN) preceptor for an accredited school of nursing, within an academic-practice partnership framework for a complete year in order to receive cancellation of his/her loan. Please complete the Employment Certification Form at the bottom and return by (**mm-dd-yyyy**), to the following:

Mail to [*Lending School Address*]: **1024 E 3rd Street Room 122, Bloomington, IN 47405** or

Fax to [*Lending School Fax#*]: **(812) 855-5848**

PART I: TO BE COMPLETED BY LOAN RECIPIENT

Name: _____

Permanent Address: _____ Phone Number: _____

Place of Employment: _____

Address: _____

Beginning Date of Employment as Nurse Faculty: Month _____ Day _____ Year _____

Position Title: _____

I **CERTIFY** that I am employed full-time as Nurse Faculty in the above-named school of nursing, and all the information is true and correct to the best of my knowledge. If I change employment status, I will notify [***Name of Lending School***] immediately. Keep a copy for your records.

Signature: _____ Date: _____

PART II: TO BE COMPLETED BY EMPLOYER

I **CERTIFY** that the statements above concerning service of the above named NFLP loan recipient as a full-time nurse faculty are true and correct. Keep a copy for your records.

Name of Certifying Official: _____

Title: _____ Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

If the above-named participant has **not** maintained faculty/clinical educator/preceptor status during this period, please provide the date(s) and explanation for the change.
Date(s): _____

Explanation: _____

WARNING: ANY PERSON WHO KNOWLINGLY MAKES A FALSE STATEMENT OR MISREPRESENTATION OF THIS FORM IS SUBJECT TO PENALTIES, WHICH MAY INCLUDE FINES AND IMPRISONMENT UNDER FEDERAL STATUTE.

Please submit completed form to:

ECSI
PO Box 1289
Moon Township, PA 15108

OR

Indiana University
1024 E 3rd Street Room 122
Bloomington, IN 47405