OMB Number: 2900-0793
Estimated Burden: 10 minutes

Department of Veterans Affairs

Health Professional Scholarship Program (HPSP), Visual Impairment and Orientation and Mobility Professionals Scholarship Program (VIOMPSP), & Veterans Healing Veterans Medical Access and Education Scholarship Program (VHVMAESP)

Annual VA Employment or Deferment Verification

HPSP/VIOMPSP/VHVMAESP: Department of Veterans Affairs, 1250 Poydras St., Suite 1000, New Orleans, LA 70113

PRIVACY ACT NOTICE

The VA is asking you to provide the information on this form under the authority of 38 U.S.C. §7502 (VIOMPSP), §7611 (HPSP), and §7601 (VHVMAESP) in order for VA to administer your scholarship award. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information for: civil or criminal law enforcement; congressional communications; the collection of money owed to the United States; litigation in which the United States is a party or has interest; the administration of VA training and scholarship programs, including verification of your eligibility to participate; and personnel administration. You do not have to provide this information to VA but, if you do not, VA may be unable to approve your deferment request. If you give VA your social security number, VA will use it to obtain information relevant to administering your scholarship award. It also may be used for other purposes authorized or required by law.

☐ HPSP ☐ VIOMPSP ☐ VHVMAESP	Participant's Name *(Last, First, MI):*	Social Security Number:
Address *(Include Street Address, City, State, and ZIP Code):*		Phone Number: Email Address:
Clinical Program while in school:		Date Degree Conferred:

☐ Submitted for Annual Employment Verification

Attach a copy of your most recent Notification of Personnel Action (SF-50) to this report.

Service Obligation Start Date:

My Current Position Title:

Grade and Step:

Name of VA Facility:

Address of Facility *(Include Street Address, City, State, and ZIP Code):*

Note: Please check all applicable blocks below. If any of the blocks are not applicable, please explain in the comments section.

☐ I have continued full-time employment throughout my service obligation.

☐ I have not been on leave without pay during my service obligation.

☐ I do not anticipate any changes to my employment status during my service obligation. If there is a change, I will notify the Scholarship Program Office as soon as I become aware of anticipated changes.

☐ I have received a satisfactory performance evaluation.

☐ Submitted for Annual Deferment Verification

Note: Submit "Education Program Completion Notice/Service Obligation Placement" if the post graduate residency will be completed within 90 days.

Start date of the Post Graduate Year (PGY) residency: _____

Anticipated Date to begin Service Obligation: _____

What PGY has been Completed: _____

Total Number of Years in the Program: _____

Name of PGY Program:

Address of PGY Program *(Street Address, City, State, and ZIP Code):*

Note: Please check all applicable blocks below. If any of the blocks are not applicable, please explain in the comments section.

☐ I have continued in my PGY Residency Program.

☐ I have received a satisfactory performance evaluation/review.

☐ I do not anticipate any changes to my educational status during my deferment. If there is a change, I will notify the Scholarship Program Office as soon as I become aware of anticipated changes.

☐ I have obtained a State Medical License to practice in the state of _____, the license number is_____.

Comments:

Scholarship Participant's Signature _____ Date _____

Supervisor/Advisor Signature _____ Date _____

Supervisor/Advisor Title/Position _____ Phone _____