



NURSE EDUCATION ASSISTANCE LOAN PROGRAM NURSE VERIFICATION FORM

SECTION I: TO BE COMPLETED BY THE RECIPIENT

INSTRUCTIONS

This form is to be used only to request partial cancellation of a Nurse Education Assistance Loan Program (NEALP). The recipient must complete Section I of this form and forward to the Personnel Officer or an Official of the employing hospital, doctor's office, institution of higher education, etc. for the completion of Section III. Upon receipt of this completed form, the State Grant and Scholarships Department of the Ohio Board of Regents will determine the recipient's eligibility for cancellation. The recipient will be informed in writing of their eligibility for cancellation and the amount. **PLEASE COMPLETE LEGIBLY.**

Name of Recipient	Social Security Number	Area Code / Telephone Number
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Address of Recipient	City	State	Zip Code
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Email Address

My signature below serves as approval for the release of any information requested in Section III of this Nursing Verification Form to the State Grant and Scholarships Department of the Ohio Board of Regents.

Signature _____	Date _____
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SECTION II: FOR STATE GRANT AND SCHOLARSHIPS USE ONLY

DATE	AMOUNT AWARDED BALANCE	AMOUNT CANCELLED	PERIOD	REMAINING BALANCE
Processed By				Date

SECTION III : TO BE COMPLETED BY PERSONNEL OFFICIAL OF THE EMPLOYMENT FIRM

The above named employee was awarded a loan through the Nurse Education Assistance Loan Program (NEALP) while pursuing his/her nursing license or degree. To assist the State Grants and Scholarships Department in verifying this recipient's eligibility for cancellation, we are requesting that you provide the following information. The recipient's signature in Section I of this form is releasing you to provide this information. If you have any questions, please contact the NEALP Administrator at 1-614-466-4818, 1-888-833-1133 Ext. 6-4818, or email nealp_admin@regents.state.oh.us. This completed form should be returned to:

**The Ohio Board of Regents
State Grants and Scholarships Department
NEALP Administrator
30 E. Broad St., 36th Floor
Columbus, Ohio 43215**

Name of Employer	
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Address of Employer	County
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City	State	Zip Code	Area Code / Telephone Number
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Date of Recipient's Employment / Contact	
_____ To _____ Month / Day / Year Month / Day / Year	

In what capacity is the recipient serving? Licensed Practical Nurse () Registered Nurse () Nurse Instructor ()
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In this capacity, how many hours does the recipient work per week? _____
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Comments:

MY SIGNATURE CERTIFIES THAT THE INFORMATION PROVIDED IN SECTION III OF THIS NURSING VERIFICATION FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ Signature of Personnel Officer / Nursing Supervisor	_____ Date
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Type / Print Name and Title

Full Mailing Address	Area Code / Phone Number
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