[Date]

[Loan Servicer Name]
[Loan Forgiveness Program Name]
[Address]
[City, State, Zip Code]

RE: Employment Verification for Loan Forgiveness

To Whom It May Concern,

This letter is to formally verify the employment of [Employee Name] at [Healthcare Facility/Organization Name]. This information is provided to support their application for the [Name of Loan Forgiveness Program, e.g., PSLF or NURSE Corps].

Employee Information:

- Full Name: [Employee Name]
- Social Security Number (Last 4 digits): [XXX-XX-0000]
- Date of Birth: [MM/DD/YYYY]

Employment Details:

- Job Title: [e.g., Registered Nurse, Physician, Clinical Social Worker]
- Employment Status: [Full-time / Part-time]
- Average Hours Worked Per Week: [Number of Hours]
- Employment Start Date: [MM/DD/YYYY]
- Employment End Date: [MM/DD/YYYY or "Present"]

Facility Certification:

I certify that [Healthcare Facility Name] is a [Type of Facility, e.g., Non-profit 501(c)(3), Government Entity, or Public Health Service Site] located in a [Health Professional Shortage Area (HPSA) - if applicable].

If you require any further documentation or information regarding this employee's service, please contact the undersigned at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Printed Name]
[Title]
[Healthcare Facility/Organization Name]
[Organization Tax ID / EIN]