

EXHIBIT D

NFLP EMPLOYMENT CERTIFICATION FORM

(Applicant's name)

entered into a contractual agreement with the University of West Georgia as a

faculty in an accredited school(s) of nursing for a complete year in order to receive cancellation of his/her loan. If full-time status is obtained through more than one part-time position, each employer must complete this form. Please complete the Employment Certification form at the bottom and return by (mail-ud-xxxx) to the following:

Fax to [Lending School Fax #]: 678-839-5649

Name: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

Beginning Date of Employment as Nurse Faculty: \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

Position Title: \_\_\_\_\_

If part-time, # of hours employed per week: \_\_\_\_\_

I CERTIFY that I am employed full-time (eight hours) as Nurse Faculty in the above named school of nursing and all the information given me is true and correct to the best of my knowledge. If I change employment status, I will notify the University of West Georgia.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Certifying Official: \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the above named participant has not maintained faculty status during this period, please provide the date(s) and explanation for the change.

Date(s): \_\_\_\_\_

Explanation: \_\_\_\_\_