



**Department of  
Higher Education**

Mike DeWine, Governor  
Randy Gardner, Chancellor

**NURSE EDUCATION ASSISTANCE LOAN PROGRAM  
NURSE VERIFICATION FORM**

SECTION I: TO BE COMPLETED BY THE RECIPIENT		
INSTRUCTIONS		
<p>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 Office of Financial Aid division of the Ohio Department of Higher Education will determine the recipient's eligibility for cancellation. The recipient will be informed in writing of their eligibility for cancellation and the amount. <b>PLEASE COMPLETE LEGIBLY.</b></p>		
Name of Recipient	Social Security Number ( <i>last 4 digits</i> ) XXX-XX-__ __ __ __	Area Code / Telephone Number
Address of Recipient	City	State
Zip Code		
Email Address		
<p>My signature below serves as approval for the release of any information requested in Section III of this Nursing Verification Form to the Office of Financial Aid division of the Ohio Department of Higher Education.</p>		
Signature _____		Date _____

SECTION II: FOR OFFICE OF FINANCIAL AID USE ONLY				
DATE	AMOUNT AWARDED BALANCE	AMOUNT CANCELLED	PERIOD	REMAINING BALANCE
Processed By			Date	

**NAME OF RECIPIENT:** \_\_\_\_\_

<b>SECTION III : TO BE COMPLETED BY PERSONNEL OFFICIAL OF THE EMPLOYMENT FIRM</b>			
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 Office of Financial Aid 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 614-466-3561 or email <a href="mailto:nealp_admin@regents.state.oh.us">nealp_admin@regents.state.oh.us</a> . This completed form should be returned to:			
<b>The Ohio Department of Higher Education Office of Financial Aid NEALP Administrator 25 South Front Street, 2<sup>nd</sup> Floor Columbus, Ohio 43215</b>			
Name of Employer			
Address of Employer			County
City	State	Zip Code	Area Code / Telephone Number
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 ( )			
In this capacity, how many hours does the recipient work per week? _____			
Comments:			
<b>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.</b>			
_____		_____	
Signature of Personnel Officer / Nursing Supervisor		Date	
Type / Print Name and Title			
Full Mailing Address			Area Code / Phone Number