

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 as a Nurse Faculty in the above named school of nursing and all the information 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: _____

I CERTIFY that the statements above concerning service of the above named NFLP loan recipient as a full-time nurse faculty are true and correct to the best of my knowledge.

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: _____