VA PORTLAND HEALTH CARE SYSTEM RESEARCH SERVICE
EDUCATION VERIFICATION FORM

All VAPORHCS research employees/applicants, VA paid and Without Compensation should complete this form.

INSTRUCTIONS: Please fill out, sign, and submit with all other forms. email VHAPOR-ResearchWOC@va.gov with questions.

1. Full Name (First, Middle, Last):

2. Social Security #: Date of Birth: Gender: ☐ M ☐ F

3. Please list ALL colleges, degrees, majors and years graduated below:

College:	College:	College:
Degree:	Degree:	Degree:
Major:	Major:	Major:
Year graduated:	Year graduated:	Year graduated:

If no college attendance/degree and no healthcare training, please answer NA:

4. Are you a resident / fellow / intern / trainee at VAPORHCS? ☐ Yes ☐ No
   If Yes, in what **clinical** area?
5. Do you or will you have clinical privileges at VAPORHCS, or are you credentialed in VetPro?
   ☐ Yes ☐ No
   If Yes, in what **clinical** area?

EMPLOYEE SIGNATURE: _____

FOR OFFICE USE ONLY:

☐ Degree Verified (Date): _____

☐ Submitted for VetPro by Clinical Service ☐ Name of Service _____

☐ RCVL/TQCVL/FCVL on file (resident/fellow/intern/trainee)

☐ Credentialing Not Required (Working in lab and/or with animals)

☐ Not Required; Other:

Reviewed by: _____ _____
Signature Date