**EMPLOYMENT & EDUCATION ATTESTATION FORM**

Please sign and submit this self-attestation to qualify for the scholarship program for long term care facility employees seeking to receive Certification for Infection Prevention (LTC-CIP) and for hospital employees seeking to receive Certification in Infection Control (CIC).

**Choose which certification you’re interested in applying for:**

[ ] Long Term Care Facility Employees - Certification for Infection Prevention (LTC-CIP)

[ ] Hospital Employees - Certification in Infection Control (CIC)

**Employer (Organization) Name:**

**Organization Address:**

**Supervisor Name:**

**Supervisor Email:**

**Supervisor Phone Number:**

**Employee Name:**

**Employee Address:**

**Employee Job Title:**

**Employee Email:**

**Employee Phone Number:**

**Educational Institution (College/University):**

**Degree:**

**Year Earned:**

**Employment & Education Self-Attestation**

In signing this form, I attest that I am employed by the above organization and have completed the education that is listed, and that all the information contained on the form is true.

\*DISCLAIMER: Signing this form indicates that you are applying for this program but does not indicate that you have been accepted. If accepted into the program, you will receive a confirmation email from the Institute of Public Health Practice, Research and Policy (cph-iphprp@uiowa.edu).\*

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

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

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