

VA St. Louis Health Care System

Research and Development Service

EDUCATION VERIFICATION FORM

In compliance with directives from VA's Office of Research and Development, it is necessary to verify credentials of employees/staff involved in the conduct of research at the VA St. Louis Health Care System. To assist completing this process, please provide the following information. Your signature below authorizes the Veterans Health Administration and the VA St. Louis Health Care System to use and/or disclose the information that you have provided on this form to the extent needed to verify your credentials. This information will be maintained confidential and used and/or disclosed to complete the verification process as described herein.

EMPLOYEE NAME		Maiden/Married Name <i>(name change if necessary for verification)</i>	
UNIVERSITY/PROGRAM ATTENDED			
CITY / STATE / COUNTRY			
DEGREE/TRAINING		DATE EDUCATION COMPLETED	
LICENSE/REGISTRATION STATE			
ISSUE DATE		EXPIRATION DATE	
CERTIFICATION		ISSUE/AWARD DATE – EXPIRATION DATE	
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
EMPLOYEE NAME		EMPLOYEE SIGNATURE	

FOR OFFICE USE ONLY

DATE OF VERIFICATION	DEGREE/CERTIFICATION VERIFIED
SOURCE OF VERIFICATION	VERIFICATION COMPLETED BY