The Care for Washington Nursing Loan Program
Certification Form

INSTRUCTIONS: Please read this form carefully and provide all requested information. Have your employer sign and date the form. If your current employer cannot certify that you have met the 36 month work requirement detailed below, please submit additional form(s) certified by your prior employer(s) so that Navient receives sufficient employer certification that you have worked full time for at least 36 months, as described below. Return the completed form to Navient, PO Box 9500, Wilkes-Barre, Pa. 18773-9500**.** This completed form(s) must be received by Navient no later than 60 months after the initial repayment begin date on the qualifying Stafford loans described in Section 2 below.

SECTION 1: BORROWER INFORMATION

NAME	ACCOUNT NUMBER	(AREA CODE) TELEPHONE NUMBER
STREET ADDRESS		
CITY	STATE	ZIP CODE

SECTION 2: REQUIREMENTS

Eligibility requirements:

- Must have a qualifying Federal Stafford Loan first disbursed no earlier than 7/1/06 with a participating Navient lender brand or lender partner in the Care for Washington program.
- Must have become a licensed LPN, RN, or RN Advanced Practice Nurse after receiving the qualifying Stafford Loan(s).
- Must have worked full-time as a Nurse or Nurse-Administrator at an eligible healthcare facility or program in the State of Washington for at least 36 months since entering repayment on the qualifying Stafford Loan(s). Eligible programs and facilities include, but are not limited to hospitals, clinics, doctors' offices, school nurse programs, public health programs, the Red Cross, hospice programs, nursing homes, or healthcare agencies providing home healthcare, that require a nursing license of LPN, RN, or an RN Advanced Practice Certification.

I certify, to the best of my knowledge and belief, that I meet the criteria listed above.

Borrower Signature Date

SECTION 3: EMPLOYMENT CERTIFICATION (To be completed by the employer. Please be sure to fill in all the blanks.)

I certify, to the best of my knowledge and belief, that the borrower named above has worked full time as a Nurse or Nurse-Administrator at an eligible healthcare program, facility, or school, as described in section 2 and listed below, in the State of Washington for_____ months within the last 5 years.

I certify, to the best of my knowledge and belief, that the healthcare facility, school, or program named below meets the following criteria:

- Requires its Nurses or Nurse Administrators to have a nursing license of LPN, RN, or RN Advanced Practice Certification.

Place of Employment Employer Identification Number (EIN)

Business Address (Street, City, State, Zip) Telephone

Chief Administrative Officer's Name and Title (Printed)

Chief Administrative Officer's Signature Date

SECTION 4: BENEFIT AWARD

Note: The Care for Washington benefit will be awarded as a principal balance reduction on your qualifying Stafford Loans described in section 2 above. Once awarded, you may view the benefit amount at Navient.com.