

HARVARD LAW SCHOOL LIPP
WASSERSTEIN SUITE 5027
CAMBRIDGE, MASSACHUSETTS 02138
TEL: (617) 495-0643
lipp@law.harvard.edu

EMPLOYER CERTIFICATION FORM

PART I: RELEASE FOR EMPLOYER CONTACT (to be completed by applicant)

Name: _____

Through my signature on this Employer Certification Form:

I authorize my employer at _____
to provide the information requested in PART II of this form to Harvard Law School
for participation in the PSLF-Based Plan.

I understand that the LIPP office may contact my employer at any time regarding
verification of my employment.

Applicant Signature: _____ Date: _____

PART II: CERTIFICATION (to be completed by employer)

The above named individual has applied to the PSLF-Based Plan at Harvard Law School. Please
complete this form and return it to the applicant. If you have questions, please contact us.

* If wages are not paid in US dollars please list the salary in the local currency and indicate the currency used.

Job Title: _____

Job Description: _____

Date **full-time** employment began: _____ End date, if known: _____

Monthly Gross Salary:* _____ Yearly Gross Salary:* _____ Effective Date: _____

Anticipated Salary Increase: _____ Date of anticipated increase: _____

Is employee eligible for over-time or shift-differential pay? _____

If yes, please provide gross amount of overtime received during July - Dec 2023:

_____ and anticipated gross amount for Jan - June 2024:

_____.

*If **part-time** employment, please specify effective date(s) and hours/schedule:

EMPLOYER CERTIFICATION FORM FOR PSLF-BASED PLAN, page 2

Applicant's Name: _____

Please list any bonuses with the date the bonus was or will be awarded:

Bonuses received to date in 2023

Bonuses anticipated through June 2024

Gross Amount(s)	Date(s)
_____	_____
_____	_____
_____	_____
_____	_____

Gross Amount(s)	Date(s)
_____	_____
_____	_____
_____	_____
_____	_____

Please identify any allowances or reimbursements associated with this position, including housing, food, travel, phone, internet, car, or loan repayment. Please indicate **type, amount, and whether the funding is a reimbursement or W2 income**:

Please detail any other benefits associated with this position:

Employer status (Please check appropriate section – this information is necessary for tax reporting purposes):

1. Government/public agency: Federal State County City Other
2. Private, non-profit 501(c)(3) organization: (check if application is pending on 501(c)(3) status):
3. Private, non-profit, organization **without** 501(c)(3) status:
4. Private, for profit organization:
5. Non U.S. private, non-profit organization:

Authorized Signature

Printed Name and Title

Date

Name of Employer: _____

Address: _____

Phone Number: () _____