



# Society for Pediatric **Interventional** Radiology

## Employment Verification for Allied Health Professional

To whom it may concern:

Please accept this letter as verification that \_\_\_\_\_ is currently employed with us in the following capacity:

\_\_\_\_\_ Technologist/radiographer

\_\_\_\_\_ Nurse/Nurse Practitioner

\_\_\_\_\_ Physician's Assistant

\_\_\_\_\_  
Printed name of Program Director or Department Head

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Program Director or Department Head

Name of Institution: \_\_\_\_\_