Early Learning Coalition of Florida's Heartland, Inc.

www.elcfh.org

# VERIFICATION OF EMPLOYMENT / LOSS OF INCOME

Employer,
Complete this form in its entirety and return to our office **before 3pm,** ____________________
If you have any questions, please contact Client Services at cs@elcfh.org

## To be completed by employer ONLY

Employee: ____________________ Employer: ____________________
Address: ____________________ Address: ____________________
City, Zip: ____________________ City, Zip: ____________________
Social Security No: ____________________ Telephone: ____________________
Hire Date: __________ Job Title: ____________________ Type of work: ____________________

*Is this a seasonal or temporary position:* ☐ *yes* ☐ *no* *If yes, date position begins:* __________ *ends:* __________

Rate of pay: $ __________ *per* ☐ *hour* ☐ *day* ☐ *week* ☐ *bi-weekly* ☐ *twice a month* ☐ *monthly*

**Weekly Work Schedule**

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Start time | | | | | | | |
| End time | | | | | | | |

**Record of Pay Received for Last 4 Weeks**

| Pay Date | Hours Worked | Gross Earning | Tips | Net Pay |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If hours or rate of pay has varied in the above, please state why. ____________________

**Loss of employment:**

* Last day of employment: ____________________
* Reason for employment loss: ____________________
  - Is the loss permanent or temporary? __________ If temporary, date of expected return: __________

The information I have provided is true and complete to the best of my knowledge. I am aware that if I provide false information I may be subject to prosecution for fraud.

Signature of employer or company designee | Printed name of person completing form | Date of signature

Fax number | Email address

Updated: 04/03/17

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*"INVESTING IN CHILDREN – INVESTING IN OUR FUTURE"*