

EMPLOYMENT VERIFICATION

The following information is requested to justify enrollment in a subsidized child care & development program for your employee. All information provided will be held confidential. Please fax to 707-444-8298 or email to info@changingtidesfs.org Thank you for your cooperation.



Parent /Employee Name _____

My signature authorizes Changing Tides Family Services staff to verify information relating to my employment.

Parent Signature _____ Date / /

THE FOLLOWING MUST BE COMPLETED SOLELY BY THE EMPLOYER - USING BLUE OR BLACK INK

Job Title: _____ First Date of Employment: / / Date Schedule Changed: / /

Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time in	:	:	:	:	:	:	:
Time Out	:	:	:	:	:	:	:
Check probable work days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Minimum hrs/week _____ Maximum hrs/week _____ Duration of Meal Time Given Each Day: _____

Check here if temporary work If temporary, expected date employment will end _____

Check here for on-call only work schedule Occasionally Works Extra Hours or Days: Yes No

Frequency of pay: Weekly Every Other Week Twice a Month Monthly

Dates checks issued to employees _____ (i.e. every other Friday, 10th and 25th)

Employee receives the following: Bonuses Tips Overtime Commission

Gross Monthly Salary \$ _____ or Hourly Rate \$ _____

I verify under penalty of perjury that this information is complete and correct.

Business Name _____ Phone (____) _____ Fax (____) _____

Physical Address _____ City _____ Zip Code _____

Legal Signature of Employer/Authorized Designee _____ Printed Name _____ Title _____ Date _____

***** For Office Use Only – Independent Verification as Required by State Regulation *****

Received by Fax or Email Directly from Employer: Yes No Verified by Phone: Yes No

Name of Contact _____ Date of Verification _____ Staff Initials _____

CM verified that employee receives : Bonuses Tips Overtime Commission None of these Duration of Meal Period _____

Notes: _____

For Changes Only: Verified by Phone: Yes No Effective Date of Change: _____

Name of Contact _____ Date of Verification _____ Staff Initials _____

Notes: _____ May 2012