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** ____________________
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:* __________

Weekly hours __________ 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 ____________________

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United Way

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"INVESTING IN CHILDREN – INVESTING IN OUR FUTURE"