Life Path Systems
Local Behavioral Health Authority

Employment Verification Form

Date: _____

Employee Name: _____ Job Title: _____

This letter is to certify that _____ is/was employed with

_____.

His/Her dates of employment are/were _____ to _____.

Presently Employed: Yes ___ No___ Date Hired: _____ Last Day Employed: _____

Current Wages/Salary $_____ (circle one)
Hourly Weekly Biweekly Semi-Monthly Monthly Yearly Other _____

Average # of hours per week: _____ Average # of Overtime hours per week:_____

Over time rate: $_____ Commissions, bonuses, tips, other $_____

List any anticipated changes in employees rate of pay over next 12 months:_____

What date are the anticipated changes going to start?_____

If employee's work is seasonal or sporadic, please list any lay off periods:_____

_____ _____ _____
Employers Signature Employers Printed Name Date

_____
Employer (company) Name and Address

_____ _____ _____
Phone Fax Email

I understand that by the signing of this letter, I am confirming that the above information is true to the best of my knowledge.

I also understand that providing false and/or misrepresented information could result in the loss of benefits.

_____ _____ _____
Client's Signature Client's Printed Name Date