Early Learning Coalition of the Nature Coast

SCHOOL READINESS PROGRAM
VERIFICATION OF EMPLOYMENT

SECTION 1: EMPLOYEE/CONTRACTOR INFORMATION (To be completed by employee)

Employee Name: _____ SSN: _____

The person named above is applying for School Readiness services, which are funded through state and federal grants. In order to receive these services, the individual must provide proof of earned income. The individual has reported an employment or contractual relationship with your business and as a result, **we are requesting that a management level employee of your business complete the sections checked ☒ below**.

☐ **SECTION 2: EMPLOYER INFORMATION**

Employer Name: _____ Phone Number: _____

Address _____ City, State, Zip _____

☐ **SECTION 3: WORK SCHEDULE AND PAY**

Hire date _____ Rate of pay _____ Total hours per week_____ Number of days per week_____

Is this a seasonal or temporary position? ☐ Yes ☐ No If yes, what are the dates of the regular season: Start Date: _____ End Date: _____

INDICATE DAYS WORKED
- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday
- ☐ Sunday

DOES THIS EMPLOYEE RECEIVE ANY OF THE FOLLOWING:
- ☐ Tips
- ☐ Bonuses
- ☐ Commission

If yes, how often: _____
Estimated Amount: $_____

INDICATE FREQUENCY OF PAY:
- ☐ Weekly
- ☐ Bi-weekly
- ☐ Semi-monthly
- ☐ Monthly
- ☐ Other: _____

WILL THE EMPLOYEE RECEIVE A STANDARD PAYSTUB?
☐ Yes ☐ No

DATE OF FIRST PAYCHECK _____

☐ **SECTION 4: CHANGES IN WORK SCHEDULE OR JOB LOSS**

Date of change _____ Rate of pay _____ Total hours per week_____ Number of days per week_____

Check days worked: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ Days Vary

Individual was ☐ Terminated or ☐ Resigned Last day of employment_____ Employer's Signature_____

☐ **SECTION 5: MEDICAL LEAVE** Start Date: _____ Anticipated Return Date: _____

Please indicate if the medical leave is related to any of the following:
- ☐ The birth of the employee's child or the need to care for a newborn child
- ☐ The adoption of a child or the placement of a foster child with the employee within the last year
- ☐ The employee must care for his or her spouse, child, or parent who has a serious health condition
- ☐ The employee has a serious health condition that makes the employee unable to perform the essential functions of his or her job
- ☐ An emergency arising out of the fact that the employee's spouse, son, daughter, or parent is a military member on active duty
- ☐ The employee is a service member with a serious injury or illness
- ☐ The employee is the caregiver spouse, son, daughter, parent, or next of kin of a seriously injured or ill service member

☐ **SECTION 6: EMPLOYER CERTIFICATION:** *I certify that the information provided on this Verification of Employment Form is true, accurate, and complete. I understand that knowingly providing false, misleading, or falsifying employment or income information may constitute fraud and may result in administrative or criminal action, as applicable.*

Employer's Name: _____ Title: _____

Employer's Signature: _____ Date: _____

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