

**Request for Employment Verification**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax/Email: \_\_\_\_\_

Phone: \_\_\_\_\_

The following individual is an applicant for or recipient of public assistance. His/her signature below authorizes the release of wage information requested on this form and the release of any information regarding his/her employment or termination of employment. His/her signature hereby releases said company (employer) from any liability for any damage resulting from disclosure of this information. We would appreciate your assistance in providing the information marked below.

_____ Employee Name	_____ Employee Signature	_____ Date
_____ Employee SSN	_____ MDHS Worker Signature	_____ Date

**Current Employee**

Date Hired \_\_\_\_\_ Start Date \_\_\_\_\_ Type of Job \_\_\_\_\_

Hourly Wage \_\_\_\_\_ Hours per Week \_\_\_\_\_ Scheduled Overtime Hours \_\_\_\_\_

How often paid?  Daily  Weekly  Semi-Monthly  Every Two Weeks  Monthly

Day of week paid:  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

For the first pay period provide: Date Payroll Ends \_\_\_\_\_ Date the first check received \_\_\_\_\_

List any tips, commissions, bonuses, vacation pay, or any other pay above the regular wages paid to employee \_\_\_\_\_

Does the employee participate in a company savings plan?  Yes  No

Are any changes expected within the next few months?  Yes  No If yes, please explain \_\_\_\_\_

**Former Employee**

Date employment ended/leave started \_\_\_\_\_ Date of Final/Last Check \_\_\_\_\_ Gross Amount of Check \_\_\_\_\_

Reason for employment ending or leave taken: \_\_\_\_\_

**Wage Information**

On the chart below please provide the following wage information for income received from \_\_\_\_\_ to \_\_\_\_\_.

Date Pay Period Ended	Date Employee Received Check	Actual Hours	Gross Pay	Other Pay (tips, EITC, etc)	Type of Other Pay

Employers who hire a public assistance recipient may claim certain federal credits. Contact your Mississippi Department of Employment Security Office or tax accountant for additional information.

\_\_\_\_\_  
Signature of person completing the form

\_\_\_\_\_  
Name of Business (complete or use business stamp)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax Number