

## EMPLOYMENT AND WAGE VERIFICATION STATEMENT

The employee below has been requested to provide the following information to the Child Care Specialist. If you have any questions regarding the use of this form or the information requested, please contact the Child Care Specialist. Please FAX the completed form to the FAX number or Email address below.

Employee's Name (Last, First, M.I.) \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
*Optional*

Child Care Specialist \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Office/District Email Address \_\_\_\_\_

I am authorizing the employer to release the information requested below.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Signed release attached. A photocopy or facsimile of a client's or employee's signature shall be treated as an original signature.

### EMPLOYER INFORMATION

Employer's Name \_\_\_\_\_

Address (No., Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

### EMPLOYEE EMPLOYMENT INFORMATION (Must be completed by the Employer)

#### NEWLY EMPLOYED / RETURNING TO WORK

Hours	
Number of Hours Worked Per Week (If hours per week vary, indicate the average per week)	
Number of Overtime Hours Always Worked Per Week	
Wages	
Hourly Wage \$	Hourly Overtime Wage \$
Does the employee receive tips? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, anticipated weekly amount \$
Does the employee receive commissions? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, amount \$
Frequency Paid (Check one): <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly (every two weeks) <input type="checkbox"/> Semi-monthly (twice per month)	
<input type="checkbox"/> Other: _____	
Date Started:	Date of First Check:
	Date of First Full Check:
	Gross Amount of First Full Check \$

#### CURRENTLY EMPLOYED (Most recent check issued)

Date Last Check Received: \_\_\_\_\_ Pay Period Ending: \_\_\_\_\_ Actual Date Paid: \_\_\_\_\_

Gross Earnings: \_\_\_\_\_ Hours: \_\_\_\_\_ Tips: \_\_\_\_\_

Frequency Paid (Check one):  Weekly  Bi-weekly (every two weeks)  Semi-monthly (twice per month)  
 Other: \_\_\_\_\_

#### IF NO LONGER EMPLOYED

Last Date Worked: \_\_\_\_\_ Gross Amount of Last Paycheck Received: \_\_\_\_\_

Date of Last Paycheck: \_\_\_\_\_ Termination Date: \_\_\_\_\_

### EMPLOYER SIGNATURE AND INFORMATION (Required)

Name of Person Completing Form (Type or print) \_\_\_\_\_

Job Title \_\_\_\_\_ Name of Company \_\_\_\_\_

Company Phone No. \_\_\_\_\_ Company Fax No. \_\_\_\_\_

Signature of Person Completing Form \_\_\_\_\_ Phone No. \_\_\_\_\_ Date \_\_\_\_\_

### FOR DES / CCA USE ONLY

Signature of CCA Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities  
• To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD  
Services: 7-1-1 • Disponible en español en línea o en la oficina local.