



Employment Verification

Employer: Please complete the following information on the employee whose signature appears below.

Please print legibly. Please return the completed form to:

Think Small
Attn:
10 Yorkton Court
St. Paul, MN 55117-1065
PHONE: 651-641-6
FAX: 651-641-3552

.....
Name of Employer: _____ FEIN # _____ - _____

Address of Employer: _____
Street City State Zip

Name of Employee: _____ Social Security No: _____

Job Title: _____ Date Employment Began: _____

Type of Job (Circle One): Permanent Temporary
If job is temporary, expected completion date: _____

Is Employee is returning to employment after a break in employment, leave of absence, or a medical leave (Circle One): YES NO

If Yes: Last date worked before leave started: _____ Return to work date: _____

Work Schedule:

The normal work schedule is (Circle One): Regular Variable

What is the normal number of hours per week? _____ What is the least number of hours per week? _____

Please complete the typical two-week work schedule below. Please record the start and end times for each day (example: 8am-5pm).

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Total Hours |
|----------|--------|--------|---------|-----------|----------|--------|----------|-------------|
| Week One | | | | | | | | |
| Week Two | | | | | | | | |

Wage Information:

Rate of Pay: _____ Date of Last Raise: _____ Health Insurance? Yes No

How Often Paid (Circle One)? Weekly Every Two Weeks Twice a Month Monthly Other: _____

Signature of Employer Representative

Date

Printed Name of Employer Representative (Please print legibly.)

Title Phone Number

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I hereby authorize my employer to release the above information to the requesting party.

Employee Signature

Date