REQUEST FOR EMPLOYMENT VERIFICATION

Section 1-To Be Completed By Applicant

Family Choice Healthcare's Employment Policy mandates that each applicant's current or previous employment be verified. Please provide all the information requested below.

PLEASE COMPLETE TOP PORTION ONLY!!!!

All responses are kept confidential and used for employment purpose only.

Your signature below gives your current/previous employer permission to complete and return this verification to Family Choice Healthcare.

Employer Name:_____
Employer Address:_____
Employer Telephone:_____

_____	_____	_____
Applicant Name (Print)	**Applicant Signature/Date**	**Applicant Telephone**

Section II- To Be Completed By Employer Only

Dear Employer,

Please provide the following information as it relates to the above applicant. All information is kept confidential. This form may be returned by fax or mail to:

Family Choice Healthcare
4601 Forbes Boulevard, #320
Lanham, Maryland 20706
Office: 888.358.1341 ext. 103
Fax: 301.200.4723

Hire Date:_____ **Resignation/Termination Date:_____**

Position(s) Held: _____

Salary: _____

Reason for Resignation/Termination:_____

Eligible for Rehire? _____Yes _____No

Additional Comments:

_____
_____
_____
_____

_____	_____
Employer Name/Title	**Employer Signature/Date**