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
1930 South Broad Street, Unit 22
Philadelphia, PA 19145
Office: 267.202.1164 ~ 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**