Family Choice™ Healthcare

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