EMPLOYMENT RECORD AND PAYROLL CERTIFICATION FORM

TO:			_ DATE:									
			SSN:	BD:								
To V	Whom	n It May Concern:										
Emp	Employment and payroll record information on the above-named individual is being requested. Your immediate											
attention to this matter is appreciated. Please respond by: Thank You.												
		(Eligibility Worker)	(TT: A d	dress / Telephone Number)								
I,												
I,, hereby give my permission for the release of information to the Department of Human Services regarding my employment and earnings.												
		(Applicant/Recipient's Signature)		(Date)								
	1.	Starting and ending dates of employment: From:		To:								
	2.	Nature of employment:										
	3.	Reason for and type of termination from employment (i.e., quit, fired, laid-off):										
		. Last day worked:										
	4.	Is there any possibility of your re-employing this individual now or anytime in the future?										
		If YES, approximate date:										
	5.	Is this individual entitled to a pension?										
		each payment (attach separate sheet).										
	6.	Did this individual receive any sick pay, vacation pa	y, or severa	ance pay upon termination?								
		If YES, furnish date and a	mount of ea	ach payment (attach separate sheet).								
	7.	Did this individual receive any cash payments or con	nmissions (other than those recorded in wage or								
		salary pay records? If yes, date and	l amount of	Eeach payment (attach separate sheet).								
	8.	Did this individual receive compensation, gifts, rewa	ards, or pre	miums in place of financial payments?								
		If YES, please describe type of compensation and date given (attach separate sheet).										
	9.	Did this individual apply for and receive any Workn	nen's Comp	pensation or Temporary Disability								
		Insurance claim payments while employed by you?		If YES, furnish dates and								
		amount of each payment or give the name of the insurance carrier or other agency providing benefits:										
	If NO, state reasons for ineligibility.											
		ii no, state reasons for inengionity.										

<u> </u>	Is health insurance available? YES NO Was this individual covered by any health											
	plan(s)? If	YES, Plan	and No.:	Type of coverage (i.e., basic,								
			Effective date:									
Names of persons covered by plans:												
Termination date of health insurance plan:												
11. If health insurance is not available, please state reason(s) why the employee is not eligible for												
service.												
<u> </u>					ords for the period from: to:							
				Please indicate if weekly, bi-weekly, semi-monthly, or monthly pay								
by listing all pay dates. Gross is pay by dates paid, not pay period ending dates. Continue on												
separate sheet, if necessary.												
Mo.	Pay Period	Date	Hours Reg/OT	Hourly	Gross	Tips	Advance	Commissions	Medical			
& Yr	Ending Date	Paid	Reg/O1	Rate	Pay		EIC		Premiums			
Addition	nal Comments:											
	ndersigned, certification and	-		-	ed is a true	and corr	ect extract f	From the employ	ment and			
Employ	er's Representa		Job Title:									
Signature:				Phone:			Date	Date Prepared:				

DHS 1266 (2/03)

Distribution: Original to Employer; Copy to Case File