COUNTY OF FRESNO

Employment Verification When Job Ends

Date:
Case Name:
Case Number:
Worker Name/Number:
Worker Phone Number:
Worker Office Address:

Employee:

I. EMPLOYEE: Sign and date below, and have your employer complete Section II. Please return by:__________

I consent to the release of information requested below to ____________________:

Signature: ____________________ Date: ____________________

II. EMPLOYER: Business Name/Address: ____________________

Please enter requested information & return completed form to: ☐ Employee ☐ Above checked address

1. Has employee stopped working? ☐ No ☐ Yes

   If yes, the reasons: ☐ Employee quit ☐ Employee laid off ☐ Employee fired ☐ Leave of Absence
   Please explain reason: ____________________

2. When was the last day the employee worked: ___/___/___

3. Number of hours employee worked last month: __________ this month: __________

4. Date and gross amount of last pay: ___/___/___ $__________

5. Are any other payments to be received (e.g. vacation/sick pay, profit sharing, retirement)? ☐ No ☐ Yes
   If yes, explain: ____________________

6. Was employee receiving health insurance benefits: ☐ No ☐ Yes
   If yes, who was covered on policy? ____________________
   If yes, when is effective termination date of health insurance? __________

7. Is full or part time work available now or in the near future? ☐ No ☐ Yes. If yes, indicate how many hours are available and when the employee can start working those hours: ____________________

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Person providing information (print & sign name) Title Phone Number Date