COUNTY OF HENRICO DEPARTMENT OF SOCIAL SERVICES

P.O. Box 90775
Henrico. VA 23273-0775
Fax: (804)501-4006

Ty F Parr
Director

EMPLOYMENT VERIFICATON FORM

EMPLOYEE NAME: _____ EMPLOYER NAME: _____
ADDRESS: _____ ADDRESS: _____
_____ _____
PHONE: _____ PHONE: _____

I, the undersigned, authorize the following information to be given to the Department of Social Services.

_____ _____
Print Employee Name Employee Signature

TO BE COMPLETED BY EMPLOYER ONLY

Current Employment Information

Date Employed: _____
Employee's Status Prior to COVID-19: ☐ Full Time ☐ Part Time ☐ Not Employed
Frequency of Pay: _____
Date Last Check Received: _____
Hourly Rate: _____
Average # Hours worked weekly pre-COVID-19: _____

Did the employee experience any of the following adverse impacts as a result of COVID-19:

- ☐ Laid Off (Permanent)
- ☐ Reduced Hours
- ☐ Paid Voluntary Leave of Absence
- ☐ Furloughed (Temporary)
- ☐ Pay Cut
- ☐ Unpaid Voluntary Leave of Absence

☐ Check here if employment was not impacted by COVID-19

Please describe the impact due to COVID-19 to the employee:

Dates of Impact: _____ _____
Start End

Estimated Hours Lost to Date: _____ Estimated Loss of Income: _____

_____ _____
Printed Name of Person completing this form Title

_____ _____
Signature of Person completing this form Phone #

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