



**EMPLOYMENT VERIFICATION FORM:**

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Job Title: RN       L&D       NICU/SCN

Hospital Employed: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_

Employed From: \_\_\_\_\_ to: \_\_\_\_\_

I authorize my employer to verify the information I have provided. I release such person from liability for providing such information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**FOR HOSPITAL COMPLETION ONLY:**

Is the information above correct?       YES       NO

Is this employee eligible for rehire?       YES       NO

If no, why: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Job Title: \_\_\_\_\_

Please fax back to: 630 551-0075  
630 551-0055 Phone