



DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES  
DIVISION OF PUBLIC WELFARE  
BUREAU OF SOCIAL SERVICES ADMINISTRATION  
194 Hernan Cortez Avenue, Suite 309  
Hagatna, Guam 96910-5052  
Telephone No: (671) 475-2653/2672



**EMPLOYMENT VERIFICATION**

**Note: This form is to be filled out by the employer. Please type or print legibly in black or blue ink.**

1. Name: _____ (Last Name) (First Name) (M.I.)	Date of Birth: _____
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2. Place of Employment: _____	Tel No: _____
Address: _____	

3. Position/Title: _____	Date of Hire: _____
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4. Employment Status: <input type="checkbox"/> Full Time			
<input type="checkbox"/> Part Time			
<input type="checkbox"/> Other (Please specify): _____			
<input type="checkbox"/> Regular	<input type="checkbox"/> Limited Term	<input type="checkbox"/> Seasonal	<input type="checkbox"/> On-Call
<input type="checkbox"/> Contractual	<input type="checkbox"/> Other (Please specify): _____		

5. Gross Monthly Income: \$ _____
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**I certify that the information provided above is true and correct.**

Certifying Official (Print Name): \_\_\_\_\_

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

Position/Title: \_\_\_\_\_

Contact Number(s): \_\_\_\_\_