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: _____
2. Place of Employment: _____	Tel No: _____
Address:	
3. Position/Title: _____	Date of Hire: _____

4. Employment Status: [ ] Full Time
[ ] Part Time
[ ] Other *(Please specify)*: _____

[ ] Regular [ ] Limited Term [ ] Seasonal [ ] On-Call
[ ] Contractual [ ] Other *(Please specify)*: _____

5. Gross Monthly Income: $ _____

I certify that the information provided above is true and correct.

Certifying Official *(Print Name)*: _____

Signature: _____ Date: _____

Position/Title: _____

Contact Number(s): _____