



VERIFICATION OF EMPLOYMENT AND INCOME
Northwest Georgia Regional Commission
Eligibility – Workforce Innovation and Opportunity Act (WIOA)

Applicant

Date

Employer

Dear Human Resource Professional:

The employee (or former employee) named below has applied for, or is a family member of a person who has applied for services through the WIOA program. We are required to verify information concerning employment and income for the six-month period shown below. Please complete all information in the lower section of the form and return it to our office at the above address or the above fax number or to the employee.

We appreciate your time and assistance in this matter.

Thank you.

Sincerely,

(Name)
(Organization)

This Section to be Completed by Employee.

Permission is granted to release the following employment information:

Signature of Employee

Social Security Number of Employee

Employer, Please Provide Information Requested Below:

Name of Employee _____ Hourly Wage \$ _____

Employment Start Date _____ GROSS INCOME FROM PERIOD BELOW:
\$ _____

Employment End Date _____ From _____
(Application Date)

Termination Reason (If Applicable) _____ To _____
(6 months from Application Date)

Authorized Employer Signature/Title

Date

Email Address

Telephone Number