

BAKERSFIELD CITY SCHOOL DISTRICT



Storiann Camps
Program Coordinator
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STATE PRE-K ADMINISTRATION OFFICE, 1111-10TH STREET
BAKERSFIELD, CALIFORNIA 93304
(661) 631-4936
FAX: (661) 859-0513

Employment Verification Form

SECTION I TO BE FILLED OUT BY EACH WORKING PARENT/GUARDIAN IN THE HOME

Name of Employee _____ Employee ID #: _____
 Name of Business/Company _____ Business/Company Phone # _____
 Business/Company Address _____ City/State/Zip: _____
 Name of Child(ren) _____
 How often are you paid? Weekly Bi-weekly Twice-monthly Monthly Seasonal
(Paid every 14 days) (Paid 1st and 15th of each month)

MY SIGNATURE AUTHORIZES MY EMPLOYER TO RELEASE THE INFORMATION REQUESTED BELOW.

Applicant Signature: _____ Date: _____

RETURN TO THE ATTENTION OF:

_____ Agency Staff Name

_____ Agency Contact Number

SEND BY:

Fax: _____ Agency Fax #

OR Scan & Email:

_____ Agency Email Address

TO BE COMPLETED OR PROVIDED BY EMPLOYER

SECTION II

Hire Date: _____

Job Title: _____

Type of Schedule: SET VARIABLE ON-CALL

Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Work begins	:	:	:	:	:	:	:
Work ends	:	:	:	:	:	:	:
Check probable work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Number of Hours Typically Worked per Week: _____ Number of Months worked per year: _____

Does employee occasionally work extra hours or days: Yes No

How often are employees paid: Weekly Every Other Week Twice a Month Monthly

Does employee receive any of the following: Bonuses Tips Overtime Commissions

Please fill in Gross Monthly Salary \$ _____ or Hourly Rate \$ _____

I CERTIFY UNDER PENALTY OF PERJURY THAT THE ABOVE STATED INFORMATION IS TRUE AND ACCURATE.

Employer Name and Title: _____ Employer Signature: _____

Email: _____ Contact Phone Number: _____ Date: _____

STAFF USE ONLY (see Title 5, § 18086)

Verification: Date: _____ Time: _____

Comments/Notes: _____

Name and Title of employer representative who confirmed above information

Staff name: _____ **Staff signature:** _____

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Formulario de Verificación de Empleo

La sección I sera completada por cada padre/tutor que trabaje en el hogar

Nombre del Empleado/a _____ Empleado/a ID #: _____

Nombre del negocio/Compañía _____ Negocio/Compañía teléfono # _____

Negocio/Compañía dirección _____ Código postal: _____

Nombre del niño/a(s) _____

¿Con qué frecuencia le pagan? Semanalmente Cada dos semanas Quincenalmente Mensualmente Estacional
(Le pagan cada 14 días) (Le pagan el día 1.º y 15.º de cada mes)

MI FIRMA AUTORIZA A MI EMPLEADOR A DIVULGAR LA INFORMACIÓN SOLICITADA A CONTINUACIÓN.

Firma del Solicitante: _____ Fecha: _____

RETURN TO THE ATTENTION OF:	_____ Agency Staff Name _____	_____ Agency Contact Number
SEND BY:	Fax: _____ Agency Fax #	OR Scan & Email: _____ Agency Email Address

TO BE COMPLETED OR PROVIDED BY EMPLOYER

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