Verification of Loss of Income/Employment

Early Learning Coalition of Palm Beach County
Ready to Learn. Ready for Life.

Date: ____________________

NAME OF EMPLOYEE: ____________________

Last Four Digits of Social: ____________________

Place of Employment: ____________________

Supervisor's Name: ____________________

Business Address: ____________________

Business Phone: ____________________

Business Fax: ____________________

Date Employment Ended or Date Hours Were Cut: ____________________

Date of final check: *(if applicable)* ____________________

Employee was:

- ☐ Layed Off
- ☐ Terminated
- ☐ Temporary Work Ended
- ☐ Hours Cut from ________ per week to __________
- ☐ Other (please explain):

This information is true and correct to the best of my knowledge. I know that if I purposely give false information, I may be subject to prosecution.

______________________________ Signature of Person Completing Form

______________________________ Title of Person Completing Form

______________________________ Name of Business

______________________________ Phone

PLEASE RETURN TO:

Early Learning Coalition of Palm Beach County
2300 High Ridge Road, Suite 115
Boynton Beach, FL 34226
Fax (561) 214-7450