

VERIFICATION OF PROFESSIONAL EMPLOYMENT

TO:

HUMAN RESOURCE PERSONNEL:
Human Resource Office
SCHOOL SYSTEM OR PROFESSIONAL EMPLOYER:
STREET ADDRESS
CITY, STATE, ZIP CODE

FROM:

AUBURN SCHOOL DISTRICT No. 408 HUMAN RESOURCES Raquel Quirino Substitute Services Specialist 915 4th Street Northeast Auburn, Washington 98002



**RETURN COMPLETED
VERIFICATION, HQ, AND
CREDITS/CLOCK HOURS
TO THIS ADDRESS**

The individual whose name appears below must have previous professional employment verified. Please complete the information requested on the reverse of this form. Your assistance in establishing a correct service record for this employee is appreciated for state reporting and accurate salary schedule placements.

INDIVIDUAL'S NAME (FIRST, MIDDLE, LAST):
FULL NAME WHEN LAST EMPLOYED WITH THIS ORGANIZATION:
SOCIAL SECURITY NUMBER:
APPROXIMATE DATES OF EMPLOYMENT FOR WHICH VERIFICATION IS REQUESTED:
POSITIONS:
NAME OF SCHOOL OR DEPARTMENT

I authorize you to release all information requested in the "Verification of Employment" AND all credits and clock hours to the school district listed above.

Employee Signature

Date

VERIFICATION OF PROFESSIONAL EXPERIENCE

Employee's Name _____

Date of Birth _____

Social Security Number _____

IF WASHINGTON PUBLIC SCHOOL EXPERIENCE:

State of Washington Transfer Sick Leave Days _____

USE ONE LINE FOR EACH ACADEMIC YEAR OR CHANGE IN STATUS			CLEARLY IDENTIFY LEAVES OF ABSENCE			
POSITION	State Education License (Certification) Required	Dates of Service From Mo/Day/Yr to Mo/Day/Yr	Number of Paid Days in Full-time Year in Your Institution	Number of Paid Hours in Full-Time Day in Your Institution	Total Hours Actually Paid This Employee	
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					
	Yes or No					

Please use one line for each academic year or change in status. Clearly identify leave of absence periods.

IN ACCORDANCE WITH WAC 392-121-262: PLEASE SEND DOCUMENTATION FOR ALL CREDITS AND CLOCK HOURS TAKEN AFTER SEPTEMBER 1, 1995.

SIGNATURE OF SUPERINTENDENT OR AUTHORIZED OFFICIAL

STREET ADDRESS

TITLE

DATE

CITY

STATE

ZIP

PHONE NUMBER

PLEASE FORWARD THIS COMPLETED VERIFICATION TO THE ADDRESS DESIGNATED ON THE REVERSE SIDE OF THIS FORM.