

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SCHOOL OF SOCIAL WORK
MENTAL HEALTH STIPEND GRADUATE EMPLOYMENT VERIFICATION FORM

SECTION A (To be completed by graduate)

(Please note if any information is new)

DATE COMPLETED: _____

NAME: _____

HOME ADDRESS: _____

CITY, ZIP: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

CITY, ZIP: _____

TELEPHONE: (H) _____ (W) _____

FAX NUMBER: _____ E-MAIL ADDRESS: _____

DATE GRADUATED: _____ DATE EMPLOYMENT BEGAN: _____

DATE EMPLOYMENT CEASED (If applicable): _____

SIGNATURE: _____

SECTION B (To be completed by employer)

AGENCY NAME: _____

SUPERVISOR'S NAME: _____

EMPLOYEE'S JOB TITLE: _____

START DATE IN CURRENT POSITION: _____

END DATE (If applicable): _____

Has this employee had any interruption in employment? (i.e., medical or maternity leave) NO _____

YES _____ From: _____ To: _____

IF YES, REASON: _____

NAME OF PERSONNEL/HUMAN RESOURCES OFFICER OR REGIONAL ADMINISTRATOR

(Supervisor may sign if necessary)

AUTHORIZED EMPLOYER SIGNATURE

DATE SIGNED

PLEASE RETURN THIS DOCUMENT TO:

ATTENTION: Shyra Harris, Mental Health Stipend Program Coordinator
CSUSB, School of Social Work
5500 University Parkway, Room SBS 302C
San Bernardino, CA 92407-2397