Employment Verification Form

Date of Request:

TO BE COMPLETED BY REQUESTING ORGANIZATION:		
Requesting Organization:	Contact Person:	Title:
Organization Address:	Phone:	Email:
Information Requested For:		
Employee Full Name:	Legend Company/Facility:	Last 4 of SSN:
Employee Address:	Employee Phone:	Employee Email:

It is the policy of Legend Healthcare to provide only job title and dates of employment to requesting organizations. Salary information may be released only for current employees applying for loans. This requires submission of documentation directly from the lending organization.

TO BE COMPLETED BY AUTHORIZED LHC REPRESENTATIVE:		
Job Title:	Employment Start Date:	Employment End Date:
Authorized Representative Information:		
Name:	Title:	Date:

Please fax or email the completed form to:

Tina Shuli
Payroll Manager
tshuli@legendhc.com
Phone: 801-655-1440
Fax: 831-536-1680

Authorized Representative: *Forward completed form to the HR Department for inclusion in the employee's file.*