LOSS OF EMPLOYMENT VERIFICATION FORM

(EMPLOYER MUST COMPLETE)

I GIVE PERMISSION FOR MY EMPLOYER TO RELEASE INFORMATION TO THE EARLY LEARNING COALITION OF BREVARD.

PARENT/GUARDIAN SIGNATURE

Dear Employer:

In order to determine the eligibility of _____ for School Readiness services, please assist by answering all questions on this form and return to the **Early Learning Coalition of Brevard**.

SECTION I-GENERAL INFORMATION

1. Name of Employee: _____
2. **Date employment ended:** _____
3. Is the loss of income? _____ Permanent or _____ Temporary? If temporary, when do you expect the employee to return to work? _____

SECTION II-EMPLOYER INFORMATION

The information on this form is true and accurate. I understand that if I intentionally provide false information, I may be subject to prosecution for fraud.

EMPLOYER'S PRINTED NAME	EMPLOYER'S TITLE
EMPLOYER'S SIGNATURE	COMPANY NAME
COMPANY ADDRESS	COMPANY PHONE NUMBER
CITY, STATE, ZIP	DATE FORM COMPLETED