

Employment Verification (To Be Completed by Employer Only)

Return completed form to:

Centralized Scanning Unit (CSU)
P.O. Box 181
Concord, NH 03301
Or Fax to (603) 271-5623

Employee Name: Bohn, Joe

SSN: 235 - 123 - 469

1. NEW or CURRENT EMPLOYMENT

Date of Hire: 05/06/2015 Job Title: Executive Assistant Employer EIN: 234697

Date of First Paycheck: 06/01/2015 Frequency of Pay: **Weekly / Bi-weekly / Semi-monthly / Monthly** (circle one)

Avg. Hrs per Week: 40 Current Rate of Pay \$ 40 per: hour (hour/day) **Full time / Part time / Per Diem** (circle one)

Is this employment **Permanent / Temporary / Seasonal** (circle one)? If temporary, seasonal or per diem please explain:

Any anticipated changes in rate of pay or average hours? Yes ☐ or No ☒ (If Yes, use back of form to explain)

Does the employee work overtime? Yes ☐ or No ☒ If Yes, how often _____ # of hours _____

Does the employee have any of the following deductions?

Check all that apply and indicate the amount and frequency i.e., per week, month etc. (use back of form if more space is needed)

☐ Profit Sharing \$ _____ per _____ ☐ Savings Bond(s) \$ _____ per _____ ☐ Life Insurance \$ _____ per _____

☐ Retirement/IRA \$ _____ per _____ ☐ Other Pretax Deduction (i.e. union dues): Type _____ \$ _____ per _____

☐ Mandatory Wage Garnishments (i.e. child support): Type: _____ \$ _____ per _____

Is FIT OR FICA withheld? Yes ☐ or No ☐

Is health insurance available? Yes ☐ or No ☐

Leave of Absence:

On a Leave of Absence? Yes ☐ or No ☐ Begin Date: ____/____/____ Expected End Date: ____/____/____

Actual Date Final Paycheck was Received: ____/____/____ Gross Amount of Final Paycheck: \$ _____

Workers' Compensation **Pending / Being Paid / Denied or N/A** (circle one) Carrier's Name: _____

Short-Term Disability / Long-Term Disability or N/A (circle one) Frequency: (wkly, mth etc.) _____ Amount \$ _____

2. LOSS OF EMPLOYMENT

Date Employment Ended: 05/01/2017

Reason: _____

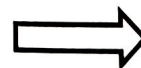
Actual Date Final Paycheck was Received: 01/02/2017 Gross Amount of Final Paycheck: \$ 6500

Did the employee receive money from another source? Yes ☐ or No ☒ If Yes, Indicate the source, type, frequency and amount (i.e., severance pay, workers comp, etc.): _____

Did the employee have health insurance? Yes ☐ or No ☒

If Yes, End Date: ____/____/____ COBRA: Yes ☐ or No ☐

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3. HEALTH INSURANCE (If known)

Does the employee have health insurance? Yes ☐ or No ☒ If **No**, did the employee decline? Yes ☒ or No ☐

1. Type (i.e., medical, vision, dental): _____ Name of Carrier: _____

Policy Start Date: ____/____/____ Policy Number: _____ Group Number: _____

Address (No., Street): _____ City: _____ State: _____ ZIP Code: _____

Self or Family (circle one) Premium Amount \$ _____ per (weekly, monthly etc.): _____

2. Type (i.e., medical, vision, dental): _____ Name of Carrier: _____

Policy Start Date: ____/____/____ Policy Number: _____ Group Number: _____

Address (No., Street): _____ City: _____ State: _____ ZIP Code: _____

Self or Family (circle one) Premium Amount \$ _____ per (weekly, monthly etc.): _____

4. WAGES RECEIVED

Complete this section for all employment types (new, current, leave of absence or loss of employment)

Please list the employee's gross wages for the last 4 weeks, **and indicate all bonuses, tips, or commissions** that are not already included in the gross wages. If the employee receives an Earned Income Tax Credit (EITC), indicate the amount of the credit.

If not already included in Gross Wages...


Actual Date Paid	Gross Wages	EITC	# of Hours	Tips	Bonus	Commission
01/09/2017	\$ 1633	\$	40	\$ 20	\$ 46	\$ 163
23/01/2017	\$ 1633	\$	40	\$ 36	\$ 49	\$ 221
15/01/2017	\$ 1633	\$	40	\$ 24	\$ 233	\$ 104
07/01/2017	\$ 1633	\$	40	\$ 41	\$ 400	\$ 136

Are **ALL** types of tips indicated? Yes ☐ or No ☐ If **NO**, explain: _____

Additional Information: _____

Thank you for your cooperation!

If you have any questions or need help completing this form please call our Customer Service Center at:
1-844-ASK-DHHS (1-844-275-3447) or 603-271-9700

 Executive Assistant
Signature & Title of Person Completing this Form

John Doe
Printed Name of Person Completing this Form

Amazon
Company Name

212 Edison Street, Seattle
City

9/9/2025
Date

666 254 1624
Telephone Number

Fax Number

washington 01262
State Zip