



**EMPLOYMENT VERIFICATION FORM  
TO BE FILLED OUT BY YOUR DIRECT SUPERVISOR**

Name:	
Employer Name:	
Employer Address:	
City:	State: California
Zip Code:	County:

Start Date:	Job Title:
Full-time (32+ hours a week): <b>Y</b> <b>N</b>	Part-time (less than 32 hours): <b>Y</b> <b>N</b>
Average weekly hours worked:	*Direct Patient Care hours per week:
% direct patient care:	% other (please specify):
Supervisory Role: ONLY if a supervisor, please complete percentage of time below. I verify that the applicant's percentage of time is used as follows:	
% supervising:	% administration:
<b>If called upon, the applicant uses the following language(s) in addition to English while in the work environment or within the community they serve:</b>	
Language(s):	

Name (please print):	Title:
Phone/Ext.	Fax:
Email Address:	

1. I understand that, should the applicant be awarded, I agree to sign Quarterly Reports verifying that this employee is providing direct patient care until the service obligation is complete.
2. I declare under penalty of perjury that the information contained in this section is true and correct to the best of my knowledge.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*\*\*Direct patient care\*\* means the provision of healthcare services directly to individuals being treated for, or suspected of having physical or mental illness. Direct patient care includes preventive care. The first line supervision of direct patient care is considered direct patient care.*