



Address: 603 Polk Street South Bldg A., Tacoma, WA 98444
 Ph.: 253-620-5400 Fax: 253-620-5455 TTY: 253-620-5499
www.pchawa.org

Tenant **MUST** provide copies of their last
 (4) four consecutive paystubs

Verification of Employment Status

I hereby request that you release information to Pierce County Housing Authority regarding my employment. I understand that this information will be kept confidential and will be used only for program purposes.

Date: _____

Employee Name (please print): _____ Social Security Number: _____

Employee Signature of Release: _____

Name of Employer: _____

Full Address of Employer: _____

Phone: _____ Fax: _____ Email: _____

**RETURN FORM TO PCHA – DO NOT TAKE FORM TO EMPLOYER TO FILL OUT
 ** TO BE COMPLETED BY EMPLOYER ONLY, PCHA WILL SEND TO EMPLOYER****

We are required to verify the employment status for all applicants/participants in the federally assisted housing programs operated by the Pierce County Housing Authority. We ask your cooperation in supplying this required information. The personnel office, timekeeper, bookkeeper or accountant should complete the form.

Date Employment Began: _____ **Employee's Job Title:** _____

Please Complete Only the Section that Applies to the Employee's Current Situation.

1) Complete this Section if Employee is Currently Working Regular / Irregular / On-Call Hours

Base Pay: \$ _____ Per: Hour Week Month Year Average Hours Worked per Week: _____

Is this employment part of a state, local training program No Yes Program Name: _____

Is this employment work study, work first or a similar community actions employment Program Type: _____

Do you anticipate an increase in the Base Pay within the next 12 months? No Yes New rate: _____ Effective: _____

Do you anticipate any overtime in the next 12 months? No Yes Rate: _____ Hours: _____

Does the employee receive tips, bonuses, or other pay or compensation? No Yes Amount: _____ Per: _____

What were employee's gross earnings for the past 12 months? Amount: _____
 As of what date: _____

2) Complete this Section if Employee is No Longer Employed

Date of termination: _____ Last day employee actually worked: _____

Is the employee on Maternity, Parental, Medical, or other leave? No Yes If yes, anticipated return to work: _____

If yes, is employee on short/long-term disability with compensation? No Yes Amount: _____ Per: _____

Do you anticipate re-hiring this employee? No Yes If yes, when: _____

Does the employee have a current or pending worker's compensation claim? No Yes

What were employee's gross earnings for the past 12 months? Amount: _____

Name and Title of Person Completing Form: _____

Signature: _____ **Date:** _____

Email: _____ **Phone:** _____ **Fax:** _____