Government of the Virgin Islands of the United States

DEPARTMENT OF HUMAN SERVICES

Office of Childcare & Regulatory Services

INCOME VERIFICATION FORM

Employer: **Kindly assist this employee by providing up-to-date employment information.**

Thank You.

Employee
Name: _____Social Security No.:_____

Mailing Address: _____

Physical Address: _____

Name of Employer:_____

Employer's Mailing Address: _____

_____

Employer's Telephone Number: _____

Employment Status: Permanent_____ Part-time_____ Temporary _____

How many work hours per week: _____

If temporary, give dates of employment contract: _____

Date Employee Started: _____ How many work days per week _____

Annual Salary: $_____ Hourly Rate: _____

Monthly Salary: $_____ Date of last increase: _____

_____ _____ _____
Signature (Employer or Agent) **Print** **Date**

_____
Title