Verification of Employment

Date: _____

The following individual, who has applied for employment in the _____ School District, has reported that s/he was formerly employed by your school district/agency:

_____ _____

Name of Former Employee ***Social Security #***

We request that you verify years of experience and provide other information as noted below. Please return this form in the postage-paid envelope provided.

_____

Signature of Person Requesting Information

_____

Position/Title

This is to certify that the employee listed above was employed by:

☐ _____ Schools

☐ Other; please specify: _____

Beginning Date (M/D/Year)	Ending Date (M/D/Year)	Years of Service	Part-time or Full-time Status	Position(s) Held

Total Accumulated Sick Leave Days: _____

Contract Status (if applicable):_____Continuing _____Limited (4 years or less)

OPEN RECORDS REQUEST

Please provide any information contained in this individual's personnel record evidencing any disciplinary action taken while s/he was employed by your district/agency.

☐ Information enclosed/attached ☐ No disciplinary action on record for this individual

_____ _____ _____

Name & Title of Person Completing Form *Signature* *Date*

(Please Print/Type)

Transfer Request

Please return completed form to shelley.lane@menifee.kyschools.us

EMPLOYEE NAME:_____ **KHRIS NUMBER:** _____

LAST DAY WORKED: _____ **PRIOR AGENCY**#: _____

HEALTH INSURANCE: SINGLE: _____PARENT PLUS: _____COUPLE: _____FAMILY_____

LIVING WELL CDHP _____ WAIVER GENERAL PURPOSE HRA _____

LIVING WELL PPO _____ WAIVER LIMITED PURPOSE HRA _____

LIVING WELL CDHP BASIC _____ WAIVER WITHOUT HRA _____

LIVING WELL HIGH DEDUCT: _____

VISION:

BRONZE _____ EMPLOYEE _____

SILVER _____ EMPLOYEE + SPOUSE _____

GOLD _____ PARENT PLUS _____

FAMILY _____

DENTAL:

BRONZE _____ EMPLOYEE _____

SILVER _____ EMPLOYEE + SPOUSE _____

GOLD _____ PARENT PLUS _____

FAMILY _____

COVERAGE END DATE: _____

OPTIONAL GROUP LIFE INSURANCE? PLEASE LIST PLAN: _____

FSA? PLEASE LIST AMOUNT: _____

PLEASE LIST ANY VOLUNTARY BENEFITS:

Description: _____Amount per check: $_____Date Coverage Ends: _____

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Description: _____Amount per check: $_____Date Coverage Ends: _____

Description: _____Amount per check: $_____Date Coverage Ends: _____

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