Region of Waterloo
COMMUNITY SERVICES
Children's Services

EMPLOYMENT VERIFICATION

To be Completed by Employer

Name of Employee: _____

Place of Employment (i.e. name of company):_____

Start Date: _____ End Date (if applicable): _____

Is employee returning from a leave? (i.e. maternity/medical) ___Yes ___No

If so, date of scheduled return from leave: _____

Minimum to maximum weekly work hours: _____to_____

Possible work days in the week: M__ T__ W__ Th__ F__ Sat__ Sun__

Hourly wage: _____

Are deductions taken off gross pay? (i.e. CPP, EI, Income Tax, etc.) Y___ N ___

Shifts (actual shifts or possible shifts that could be worked (i.e. 9am-5pm/4-8pm/1pm-9pm)):

_____

_____

Is overtime or are additional shifts a possibility? Y__ N __

☐ **I confirm that all sections of this form have been completed**

Signature: _____

Title (Owner/Manager/Supervisor): _____

Date: _____ Contact Number: _____