EMPLOYMENT VERIFICATION FORM

Compete the top portion of this form and provide a copy to your employer for whom you are employed with. Request that they complete the form and return it to you. You will then need to turn this form in to the Allied Health Division in order to be considered for the Medical Assisting Program.

_____ _____

Last name, First name, Middle Initial Laker ID #

_____

Address

_____

City, State, Zip, County

_____ _____

Laker Email Daytime Phone Number

Please check certification for which you obtain:

___ CNA ___ EMT-B ___ Phlebotomist ___ MT ___ EMT-P ___ RT ___ Other

If other please list: _____

THIS SECTION TO BE COMPLETED BY EMPLOYER:

Dear employer: The individual above is attempting to verify satisfactory employment while he/she has been under your supervision. This form will help the above individual meet eligibility requirements for the Medical Assisting Program at Lake Land College. Please complete and return to the individual. Thank you.

Institution: _____

Address: _____

City, State, Zip, County:_____

Employer phone: _____ Email: _____

Dates of employment: _____

Employment status: _____ Full Time _____ Part time

Employer's Attestation:

Through the provision of my signature below, I hereby verify that the above-named individual is employed at this place of employment for the time duration indicated above. I further attest that during the course of employment, this individual's performance was satisfactory or competent to the work requirements and standards of this institution.

Name: _____ Signature: _____

Title: _____ Date: _____