



HOUSING AUTHORITY OF THE COUNTY OF DEKALB
310 NORTH SIXTH STREET
DEKALB, IL 60115
(815) 758-2692 FAX (815) 758-4190

VERIFICATION OF TERMINATION OF EMPLOYMENT

(Date)

(Employer Name)

(Employer Phone/Fax)

(Employer Street Address)

(Employer Email)

(Employer City, State, Zip)

We are required to verify, through the employer, the termination of employment for all applicants and tenants in our Housing Choice Voucher Program. We ask your cooperation in supplying this required information. In no event should this form be filled out by the employee. Forms should be completed by the timekeeper, bookkeeper or accountant. Thank you for your time and cooperation.

Employee's Name SSN:

Employee's Address

Date Employed Date of Termination

Last Day Employee Actually Worked YTD Earnings

Will employee receive additional pay for unused annual or sick leave? ()YES ()NO
If answer to above is yes, state amount employee will receive: \$

Will employee receive any additional pay checks for any workmen's compensation? ()YES ()NO
If yes, give name and address of company through which this may be verified:

Name of Firm Street Address City/State/Zip

Reason for Termination: ()Employee Quit ()Terminated for Cause ()Lack of Work ()Other
If terminated for lack of work or other, do you anticipate re-hiring this employee? ()YES ()NO
If yes, when?

Signature of Authorized Representative: Fax: Phone:

Printed Name: Title: Date:

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

I, , authorize you to furnish the above information to the Housing Authority of the County of DeKalb.

Date Employee Signature Soc. Sec. Number