**CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE**
**DEPARTMENT OF HUMAN RESOURCES**

# VERIFICATION OF EMPLOYMENT REQUEST FORM

**Date** ___________________

**Name of Employee :** _____________________________________

**Employee SSN:**_____________________ **Employee DOB:** _____________________

**I,** _______________________________, **am requesting a letter of verification of my employment/benefits.**

**A copy of requested document was received on (date)**_________________________.

**Signature of requestor/recipient :** ___________________**Phone no.**_________________

**Human Resources Department Authorization:** _______________________________

**Notes:**

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*Please be advised that information for employees who have been separated for more than 3 years are processed in approximately 30 days from requested date*

*5/9/2011*