



## HPOP Employment Verification Form

Please give this form to your employer to complete and provide to the information listed below. Upon completion please return to your HPOP Specialist.

Current Hourly Wage \_\_\_\_\_ Hours Worked in the Last Week \_\_\_\_\_

Employer Provides Health Insurance Yes \_\_\_\_ No \_\_\_\_

Date Hired \_\_\_\_\_ or Date of Promotion \_\_\_\_\_

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

City, State Zip Code \_\_\_\_\_

Employer Contact Phone: \_\_\_\_\_

Employer Email: \_\_\_\_\_

Employed in Health Care Occupation  Yes  No

Employer Print \_\_\_\_\_

Employer Signature \_\_\_\_\_ Date \_\_\_\_\_