FLORIDA DEPARTMENT OF HEALTH

EMPLOYMENT VERIFICATION FORM

PART I: ***TO BE COMPLETED BY APPLICANT***
Complete this part and submit a copy to your employer for completion.

Applicant Name:_____ SS#:_____

Address:_____

NAME OF PHYSICIAN OR MEDICAL FACILITY: _____

I hereby authorize release of any information regarding my employment status with your practice/medical facility to the Electrolysis Council.

Applicant Signature:_____ Date:_____

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PART II: ***TO BE COMPLETED BY PHYSICIAN/EMPLOYER OR MEDICAL FACILITY/EMPLOYER***
Please complete this part regarding the above individual and return this form to the address listed below. Thank you for your cooperation in this matter.

APPLICANT NAME: _____ SS#: _____

PHYSICIAN NAME (IF APPLICABLE): _____ LICENSE #: _____

PLACE OF EMPLOYMENT: _____

BUSINESS ADDRESS: _____
(Mailing address, city, state and zip)

POSITION TITLE: _____

DATES OF EMPLOYMENT: _____ THROUGH _____

ELIGIBLE FOR REHIRE? _____
If not eligible for rehire, please give reason on additional sheet.

VERIFIED BY: _____
Verifying Agent

DATE: _____ _____
Name

PHONE NUMBER: _____ _____
Title

DIVISION OF MEDICAL QUALITY ASSURANCE
ELECTROLYSIS COUNCIL
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