EMPLOYMENT VERIFICATION FORM

DHHS, Division of Public Health, Licensure Unit
Office of Nursing & Nursing Support
P. O. Box 94986
Lincoln, NE 68509-4986
Fax (402) 742-1151
Telephone (402) 471-4322

NURSE AIDE INFORMATION (Either the Nurse Aide or the Employer can complete this section):

Social Security Number _____

Name _____
Last First Middle Initial

Other Previously Used Last Names(s)_____

Address _____
Street Apt. # City / State Zip Code

Home Phone # _____ Work or Cell Phone # _____

Signature _____ Date_____
(optional)

EMPLOYER: COMPLETE THIS SECTION

Employer's name and mailing address:

_____

_____

_____

Employer's Telephone Number _____

Brief Description of duties performed while employed (please provide specific duties):

_____

_____

_____

All employers must complete the following section in the presence of a notary public:

I certify that the nurse aide named above (is/was) employed by me to perform nursing or nursing-related services for monetary compensation from _____ to _____.
(month, day, year) (month, day, year)

Signature _____ Date Signed _____

Title _____

Sworn and subscribed before me on this _____ day of _____, 20__, In the County of _____,

In the State of _____.

_____
Signature of Notary Public

(SEAL)

_____
Date Commission Expires

Rev 4-19