VERIFICATION OF EMPLOYMENT OF APPLICANTS FOR HEALTH FACILITY ADMINISTRATOR LICENSURE

* This agency is requesting disclosure of your Social Security number in accordance with IC 4-1-8-1; disclosure is mandatory, and this record cannot be processed without it.


## THIS FORM IS FOR ENDORSEMENT CANDIDATES ONLY.



If employee was disciplined in any way while in your employ, please provide certified copies of all related documents. Thank you for your assistance.

| AFFIRMATION |  |
| :--- | :--- |
| I hereby swear or affirm under penalties of perjury that the information provided herein is true and correct. |  |
| Form completed by (signature) | Printed name and title |
| Name of firm or business |  |
| Address of firm or business (number and street, city, state, and ZIP code) | Date (month, day, year) |
| Telephone number <br> $($ |  |

