CC-024A FORFF (10-18)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

EMPLOYMENT AND WAGE VERIFICATION STATEMENT

The employee below has been requested to provide the following information to the Child Care Specialist. If you have any questions regarding the use of this form or the information requested, please contact the Child Care Specialist. Please FAX the completed form to the FAX number or Email address below.

Employee's Name *(Last, First, M.I.)* _____ Soc. Sec. No. _____

Child Care Specialist _____ Phone No. _____ Fax No. _____

Office/District Email Address _____

I am authorizing the employer to release the information requested below.

Employee's Signature _____ Date _____

☐ Signed release attached. A photocopy or facsimile of a client's or employee's signature shall be treated as an original signature.

EMPLOYER INFORMATION

Employer's Name _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

EMPLOYEE EMPLOYMENT INFORMATION (*Must be completed by the Employer)*

NEWLY EMPLOYED / RETURNING TO WORK

Hours	
Number of Hours Worked Per Week *(If hours per week vary, indicate the average per week)*	
Number of Overtime Hours Always Worked Per Week	
Wages	
Hourly Wage $ / Hourly Overtime Wage $	
Does the employee receive tips? ☐ Yes ☐ No — If Yes, anticipated weekly amount	$
Does the employee receive commissions? ☐ Yes ☐ No — If Yes, amount	$
Frequency Paid *(Check one)*: ☐ Weekly ☐ Bi-weekly *(every two weeks)* ☐ Semi-monthly *(twice per month)* ☐ Other:	
Date Started: / Date of First Check: / Date of First *Full* Check:	
Gross Amount of First *Full* Check	$

CURRENTLY EMPLOYED *(Most recent check issued)*

Date Last Check Received: _____ Pay Period Ending: _____ Actual Date Paid: _____

Gross Earnings: _____ Hours: _____ Tips: _____

Frequency Paid *(Check one)*: ☐ Weekly ☐ Bi-weekly *(every two weeks)* ☐ Semi-monthly *(twice per month)*
☐ Other: _____

IF NO LONGER EMPLOYED

Last Date Worked: _____ Gross Amount of Last Paycheck Received: _____

Date of Last Paycheck: _____ Termination Date: _____

EMPLOYER SIGNATURE AND INFORMATION *(Required)*

Name of Person Completing Form *(Type or print)* _____

Job Title _____ Name of Company _____

Company Phone No. _____ Company Fax No. _____

Signature of Person Completing Form _____ Phone No. _____ Date _____

FOR DES / CCA USE ONLY

Signature of CCA Person Completing Form _____ Date _____ Time _____

See reverse for EOE/ADA/LEP/GINA disclosures

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Disponible en español en línea o en la oficina local.