

Verification of Temporary Leave

TO BE COMPLETED BY EMPLOYER

Employee Name: _____ **Soc Sec #:** _____

The above person has indicated that s/he is employed with your business. Please complete the following information and return to employee or directly to Jefferson County at fax number: 303-271-4447

Attn: _____ . We appreciate your time and assistance.

Name of Employer/Business: _____

Date Leave Starts: _____ Expected Return Date: _____

Last Check Date Before Leave: _____ Is Temporary Leave: Paid Un-Paid

If Paid: How often paid? Weekly Biweekly Semimonthly Monthly /Other _____

Will The Employee Be Receiving Short Term Disability? Yes No

Will The Employee Be Receiving Workers' Compensation? Yes No

If so, How often: _____ How much: _____

Employee's Pay/Work Schedule Upon Return:

First Check Date Upon Return To Work: _____ Salary: _____ hr/mo
Circle one

Taxes withheld: Yes No How often paid? Weekly Biweekly Semimonthly Monthly /Other _____
Circle one

Additional income (overtime/commission/bonuses/tips*) No Yes (if yes complete the following)

How much: _____ How often: _____ *If tips, what percentage is reported: _____

WEEKLY WORK SCHEDULE: (Please list typical schedule i.e. 9-5)

SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL HRS PER WK

If varied schedule please mark any regular days off (OFF) in box above and fill out varied schedule information below:

If **VARIED** schedule: Average hours per week _____ (min # hrs) _____ (max # hrs)

Earliest time in _____ Latest time out _____

I confirm that the above information is complete and accurate:

Printed Name

Title

Phone Number

Signature

Date