Washington State Department of Health
Home Care Aide Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Long Term Care Employment Verification Form

(to be completed by the client or employer)

Note: this form is not required if you are unemployed.

Last Name of Individual Hired:	First Name:
Middle Name/Initial:	Date of Birth of Individual:
Date of Hire (mm/dd/yyyy):	Last Date of Employment:
Job Title and Description:	
Training required on the date individual was hired:	

Note: If you have worked at some time between January 1, 2011 and January 6, 2012 in Washington State, your employer during this time frame must complete the job title and description section of this form and send proof of training requirements completed at the time of hire, which can be a certificate of completion.

Name of facility or agency, if applicable

Name of Employer or Client (print) Title (print)

Address of employer

City State Zip Code

Signature of Employer or Client

Please send completed form to the above address.