www.walkerenterprises.com

REQUEST FOR VERIFICATION

From: Walker Enterprises, PO Box 380277, B'ham, AL 35238 Tel.(205)991-5850, Fax (205)991-7868

Employee Name: _____
Date of Birth: _____
Start Date: _____ for employer:_____

I hereby authorize that the information below be released to Walker Enterprises for the **sole** purpose of applying for WOTC and WTWTC certification.

Employee Signature :_____ Date:_____
SSN# : _____

Recipient Name:_____ Relationship to you:_____

Counselor Name:_____ Phone #_____ Fax # _____

Counselor Address:

ATTENTION AGENCY PERSONNEL :
In order to obtain a Work Opportunity **and/or** Welfare to Work Tax Credit for the employee indicated above, the Department of Labor requires verification that the employee did receive the services/assistance described below. Please sign and complete below (and if attached the "Verification of Welfare and or Food Stamp Status" document) and return to Walker Enterprises at the above address. ***Thank you!***

Veteran's Administration :
Employee was/is a veteran of the U.S. Military. Please send a copy of the DD214.
Yes ( ) No ( )

Vocational Rehabilitation Agency :
Employee was receiving or had completed rehabilitative services under a written plan under a State or Veterans Administration rehabilitation program on or before start date.
Yes ( ) No ( )

Social/ Human Services Agency :- ***Please send a print out!***
Employee was a member of a household which received AFDC financial assistance, or a successor program for at least 9 months anytime within the 18 months prior to the start date:
Benefits From: To:

Felony Conviction :
Within twelve months prior to start date the employee was convicted of a felony or was released from incarceration for a felony.
Release date : Conviction date :

Food Stamp Agency: ***Please send a print out!***
The employee was continuously receiving food stamps for the 6 months prior to the start date **OR** for at least 3 of the last 5 months prior to the start date and is no longer eligible to receive them?
Benefits From: To:

SSI Agency: ***Please send a print out!***
The employee was receiving Supplemental Security Income (SSI) benefits for any month ending within the 60 days prior to the employment start date.

Agency Representative
Signature :_____
Name :_____ Title :_____Phone# : ( )