MC: EL
Bar Code Area
FS#:
Central File Maintenance
P.O. BOX 12048
AUSTIN, TX 78711-2048

CHILD SUPPORT DIVISION

Date:
Employee Name:
Employee SSN:
Employee DOB (MM/DD/YY):
Member #:

VERIFICATION OF EMPLOYMENT

Dear Employer :

The Office of the Attorney General is attempting to locate the above-named person. We have received information that this person is currently working for you or has worked for you in the past. State law requires you to provide the information requested below. [Texas Family Code Chapter 231.302] We will keep this information confidential and will use it only for the purpose of collecting child support.

IF this person is NO LONGER EMPLOYED by your company,

COMPLETE ONLY THE INFORMATION IN THE BOX on the other side.

IF this person is STILL EMPLOYED by your company,

PLEASE PROVIDE THE INFORMATION IN THE BOX AND ALL APPLICABLE INFORMATION BELOW THE BOX.

Please use the enclosed postage-paid envelope to return the form to our office. If you prefer, you may complete the form online by visiting our website at www.employer.texasattorneygeneral.gov

I certify that the information requested for this individual is required for the performance of this agency's official duties.

Thank you for your assistance.

Office of the Attorney General of Texas
Title IV-D Agency

EMPLOYER ADDRESS AND CONTACT INFORMATION

Please review your address above. Unless other information is provided by you, future correspondence from the Child Support Division (including child support orders and writs) will be sent to this address.

Is the above address correct for future correspondence? ❑ Yes ❑ No
If no, please provide correct address:

_____

_____

_____

(**see other side**)

VERIFICATION OF EMPLOYMENT

Employee Name:
Employee SSN:
Employee DOB (MM/DD/YY):
Member #:

EMPLOYEE INFORMATION

Date of Employment: Begin _____ End: _____

Occupation : _____

Home (or last known) address:

Street: _____

City: _____ St: _____ ZIP: _____

Home Telephone: _____ Date of Birth: _____

SSN (if different from above): _____

Name (if different from above): _____

New Employer (and address if known):

Name: _____

Street: _____

City: _____ St: _____ ZIP: _____

Spouse Name: _____

COMPLETE ONLY IF EMPLOYEE IS CURRENTLY EMPLOYED

Job Location (where employee works) :

Street: _____

City: _____ St: _____ ZIP: _____

Telephone: _____

Payroll frequency and pay period information:

□ Weekly: _____ day of week: _____
□ Biweekly: _____ next pay date: _____
□ Semi-Monthly _____ days of mo: _____ and _____
□ Monthly: _____ day of month: _____

Starting Salary: _____ per _____

Current Salary: _____ per _____

Shift (day/night): _____

Is dependent medical coverage available to this employee through your company? □ Yes □ No

Employer Federal ID #: _____

Does employee have an active Workers' Compensation claim? □ Yes □ No

If yes, provide name and address of the Workers' Compensation provider: _____

_____

_____

FORM COMPLETED BY: _____ DATE: _____

POSITION or TITLE of PERSON COMPLETING FORM: _____

TELEPHONE: _____ FAX Number for Payroll Department: _____

COMMENTS: _____

_____

_____

Thank you again for your assistance.