



## GASTON COUNTY SCHOOLS Verification of Experience

Name \_\_\_\_\_  
First
Middle
Last

Social Security Number (Last four digits) \_\_\_\_\_

Company Name \_\_\_\_\_

<b>Work Experience (To Be Completed By Employer)</b>				
<b>Beginning Date of Employment (month, day, year)</b>	<b>Ending Date of Employment (month, day, year)</b>	<b>Total Hours Worked Per Week</b>	<b>Position Title</b>	<b>To be Completed by GCS</b>

**To be evaluated, a brief job description from the employer must be attached.**

**I certify that this verification is complete and correct according to the official records of this business.**

\_\_\_\_\_  
 Signature of Personnel Administrator

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Telephone Number

**\*\*TO THE EMPLOYER: Please return the completed form to the employee.**