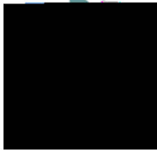

GASTON COUNTY SCHOOLS
Verification of Experience

Name ____
First Middle Last

Social Security Number (Last four digits) ______________________

Company Name ____

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

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.