



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.**