EMPLOYMENT VERIFICATION

State of Alabama Board of Examiners of Assisted Living Administrators

This statement verifies that I _____ am currently the
Name of Administrator/Owner/Supervisor/Governing authority

_____ of _____.
Title *Name of Facility/Hospital/Resident Care Setting*

I further verify that, within two years preceding the date of this application,

_____ has worked **fulltime** at this facility/hospital/resident care setting
Applicant Name
in an administrative **AND** resident/patient care position for at least three (3) months

(**Check ALL that apply**)

☐ **administrative position -** *Assists management in planning, developing, organizing and implementing office duties and other job related duties as designated.)*

☐ **resident/patient care position -** *The direct and Active involvement with residents needs and activities of daily living to include all of the following: Grooming, Bathing, Toileting, Eating, Bathing and Dressing.*

Signed: _____ Printed Name: _____

Date: _____ Phone: ( )_____

Address: _____
Street

_____
City *State* *Zip*

Dates of Employment: _____ to _____

Full Time or Part Time? _____ Hours worked per week: _____

Was/Is Position Considered Supervisory? ☐ Yes ☐ No

Please return this form to the State of Alabama Board of Examiners of Assisted Living Administrators along with your application. You may fax this form to (334) 271-2420.