KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
HEALTH OCCUPATIONS CREDENTIALING
503 S. Kansas Ave
Topeka, KS 66603-3404

TRAINEE II EMPLOYMENT VERIFICATION FORM

TRAINEE II: COMPLETE THIS SECTION

Social Security Number _____-____-_____ Date of Birth: ____/____/____

Name: _____
(Last) (First) (M.I.

Alias: _____

Address: _____
(Street) (City/State) (Zip)

Phone Number (Home) _____ Work Number: _____

Course Instructor's Name: _____

Course Instructor's Email Address: _____

Signature_____ Date:_____

EMPLOYER: COMPLETE THIS SECTION

***Only complete this form for the Trainee II listed above if they have worked a minimum of 25 HRS in Adult Care Home Setting performing activities of daily living. For the Trainee II to receive credit towards their clinical hours, this completed form needs to be sent directly to the Trainee II's course instructor listed above.**

Employer's name and mailing address: _____

_____

_____

Telephone number ( ) _____

I certify that the Trainee II named above is employed by our facility to perform duties of activities of daily living

_____ to _____ Total Hours _____

Signature _____ Date: _____

Title _____