

## **GASTON COUNTY SCHOOLS Verification of Experience**

Name					
First		Middle	La	st	
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 values business.	erification is comp	lete and correct	according to the official	records of this	
Signature of Personnel Administrator			Da	Date	
Title	e		Telephone	Telephone Number	

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