



Family Development Services
— A Head Start Organization —

DATE: ____/____/____

CENTER: _____

CHILD'S NAME: _____

Dear Sir/Madam,

Please verify employment or training hours of:

Employee Name: _____ Employee ID#: _____

Scheduled Work Hours Monday thru Friday: _____

Scheduled School/Training Hours Monday thru Friday: _____

Name and Address of Employment or Training:

Employer/Training Name: _____

Employer/Training Address: _____

City, State, Zip: _____

Employer/Training Telephone Number: _____

Signature of Supervisor: _____

Printed name of Supervisor: _____

Date: ____/____/____

Thank you,

Tyrone Humphrey Jr., M.S.
Social Services Coordinator