



A Community Partner,
Helping People to Help Themselves

Walla Walla Housing Authority

501 Cayuse Street
Walla Walla WA 99362
509-527-4542 * Fax 509-527-4574
Hearing-impaired use relay service
www.wallawallaha.org * wwha@wallawallaha.org



VERIFICATION OF TERMINATION OF EMPLOYMENT

Employer Name _____ Tenant/Applicant _____

Address _____ Social Security Number _____

Telephone _____ Telephone _____

Dear Sir/Madam:

We are required to verify, through the employer, the termination of employment for all tenants/applicants in our housing programs. Your verification is for the confidential use of this agency and the U.S. Department of Housing and Urban Development (HUD). Please furnish the information requested below and return this form to the Housing Authority at the above address.

I hereby authorize the release of this information.

Tenant/Applicant Signature

Date

** TO BE COMPLETED BY EMPLOYER **

1) Termination Date: _____

2) Reason for Termination:

() Employee Quit () Terminated for Cause () Lack of work () Other

If terminated for lack of work or other, do you anticipate rehiring this employee?

() No () Yes Anticipated re-hire date _____

3) Year to Date Gross Wages \$ _____

Signature/Title

Date

WARNING! TITLE 18, SECTION 1001 OF THE U.S. CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWING AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.