

## Employment Verification Certified Brain Injury Specialist Trainer Applicant

Information must be typewritten or neatly printed.

This section is to be completed by your immediate supervisor. If you are self-employed, a professional colleague must complete. **The previous (5) years of employment in the field of Brain Injury must be verified; separate forms must be submitted by each employer in the previous five (5) years.**

Applicant's name: \_\_\_\_\_

I hereby verify that this applicant has been employed for \_\_\_\_\_ years \_\_\_\_\_ months in a program serving persons with brain injury.

Print your name: \_\_\_\_\_

Your title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Type of Brain Injury program: \_\_\_\_\_

Applicant's dates of employment: \_\_\_\_\_ to \_\_\_\_\_

Describe duties of this applicant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional comments: \_\_\_\_\_  
\_\_\_\_\_

I hereby verify that the information provided above is true and accurate to the best of my personal knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_