

LIVINGSTON COUNTY FRIEND OF THE COURT
210 S. Highlander Way CSuite 3 CHowell, MI 48843 C(517)546-0230 CFax (517)552-2312

EMPLOYMENT VERIFICATION

Your Full Name: _____ Soc. Sec. # _____

Employment Information

Employer's Name and Address: _____

Employer's Phone Number _____

Date of Hire: _____

Health Care Information
(PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD)

Carrier: _____ Phone # _____

Policy No.: _____ Group No.: _____

Medical _____ Dental _____ Optical _____

Effective Date: _____

Dependants covered on this policy:

9 I request support services under Title IV-D of the Social Security Act.

YOUR SIGNATURE: _____ **Date:** _____