



EDUCATION VERIFICATION

I, \_\_\_\_\_ certify that the information I have provided is correct and authorize the appropriate school official to release the necessary Information to Clinical Staff Support, Inc for the purpose of verifying my education.

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

Employee Name \_\_\_\_\_

Name Graduated Under \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Educational Institution \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Degree \_\_\_\_\_

Degree \_\_\_\_\_ Date of Graduation \_\_\_\_\_

Comments \_\_\_\_\_

Verified by \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_

Please complete and return via FAX to 1-866-289-3893

CLINICAL STAFF SUPPORT,INC  
ATTN: Human Resources  
P.O. Box 446  
Round Rock, Texas 78680-0446

Phone 512-799-0935  
Fax 866-289-3893