# Certified Healthcare Internal Audit Professional™

## Employment Verification Form

### Part I. Applicant Information – To be completed by applicant

**Name:** _____ **Position Title:** _____

**Company Name:** _____

**Company Address:** _____

**Company Telephone:** _____ **Cell Phone:** _____

**Email Address:** _____

**Start Date:** _____ **End Date:** _____ **Still Employed:** ☐

**Description of Position and Duties:**

### Part II. Employer Verification – To be completed by direct supervisor or Human Resources

**The individual named above is applying for Certification through The Association of Healthcare Internal Auditors. Please print, sign and date the completed form and return to the applicant.**

**Name:** _____ **Position Title:** _____

**Nature of Association with Applicant:** Supervisor ☐ Human Resources Contact ☐

**Telephone:** _____ **Email Address:** _____

**Can you verify the employment history and title for this individual?** **Yes** ☐ **No** ☐

**If no, please explain:**

**Additional Comments:**

_____ _____

Signature Date