

**Tompkins County**  
**DEPARTMENT OF SOCIAL SERVICES**  
**Child Care Assistance Program**

320 West Martin Luther King Jr. / State Street  
 Ithaca, New York 14850  
 (607) 274-5612

**EMPLOYMENT INFORMATION**

**THIS FORM IS TO BE COMPLETED BY THE EMPLOYER ONLY**

Name of Employee: \_\_\_\_\_

Name of Employer or Company: \_\_\_\_\_

Address of the Employer: \_\_\_\_\_

May we contact employer for more information?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address \_\_\_\_\_ Employee's start date: \_\_\_\_\_

How often does employee get paid? (circle one)    Weekly    Bi-weekly    Semi-monthly

Other: \_\_\_\_\_ What day? M T W TH F SAT SUN

Is this a 10-month position (i.e. school employee) or year-round? \_\_\_\_\_

How many days per week does employee work? \_\_\_\_\_

How many hours per day does employee work? \_\_\_\_\_

Does employee have a set work schedule?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

If YES, please give the exact days and hours that employee is working:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Hourly Rate: \$ \_\_\_\_\_ or Gross Salary: \$ \_\_\_\_\_ per \_\_\_\_\_

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