STATE OF HAWAII
Department of Human Services

Benefit, Employment and Support Services Division

EMPLOYMENT RECORD AND PAYROLL CERTIFICATION FORM

TO: Windward Ford

DATE: 4/11/16

RE: Vinole, Raymond

SSN: XXX-XX-5665 BD: 2/24/65

To Whom It May Concern:

Employment and payroll record information on the above-named individual is being requested. Your immediate attention to this matter is appreciated. Please respond by: 4/21/16 Thank You.

pending team
(Eligibility Worker)

-5868047 (Telephone Number) -5868138 (FAX Number)

OR & L PROCESSING CENTER
333 N. KING ST., #200
HONOLULU, HI 96817
(Unit Address)

I, RAYMOND VINOLE , hereby give my permission for the release of information to the Department of Human Services regarding my employment and earnings.

[signature] (Applicant/Recipient's Signature) 4-11-16 (Date)

☒ 1. Starting and ending dates of employment: From: 2/10/2016 To: 2/16/2016

☒ 2. Nature of employment: Auto Salesperson

☒ 3. Reason for and type of termination from employment: ☑ Quit ☐ Fired ☐ Laid-Off

Other: ____ Last day worked(m/d/yy): ____

☐ 4. Is there any possibility of your re-employing this individual now or anytime in the future?
☐ Yes ☐ No If YES, approximate date: ____

☐ 5. Is this individual entitled to a pension? ☐ Yes ☐ No
If YES, furnish date and amount of each payment (☐ attach separate sheet of pension).

☐ 6. Did this individual receive any sick pay, vacation pay, or severance pay upon termination?
☐ Yes ☐ No If YES, furnish date and amount of each payment (☐ attach separate sheet).

☐ 7. Did this individual receive any cash payments or commissions other than those recorded in wage or salary pay records? ☐Yes ☐No If yes, date & amount of each payment ☐ attach separate sheet).

☐ 8. Did this individual receive compensation, gifts, rewards, or premiums in place of financial payments?
☐Yes ☐No If YES, please describe type of compensation & date given (☐ attach separate sheet).

☐ 9. Did this individual apply for and receive any Workmen's Compensation or Temporary Disability Insurance claim payments while employed by you? ☐ Yes ☐ No If YES, furnish dates and amount of each payment or give the name of the insurance carrier or other agency providing benefits:

____

If NO, state reasons for ineligibility. ____

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☐ 10. Is health insurance available? ☐ YES ☐ NO Who is/was covered by any health plan?

NAME	PLAN & Number	Coverage (Basic, Drug, etc)	Effective Datee	Termination Datee

☐ 11. If health insurance is not available, please state reason(s) why the employee is not eligible for service. ______

☒ 12. **Please attach copies of payroll records for the period from:** March 2016 **to:** CURRENT or enter the information below. Please indicate if weekly, bi-weekly, semi-monthly, or monthly pay by listing all pay dates. Gross is pay by dates paid, not pay period ending dates. Continue on separate sheet, if necessary.

Month /Year	Pay Period Ending Date	Date Paid	Hours Reg/OT	Hourly Rate	Gross Pay	Tips	Advance EIC	Commissions	Medical Premium	Year To Date
3/16					-0-					388.88
2/16		2/20/16	45.75	—	388.88					388.88

Additional Comments:

I, the undersigned, certify that the information provided is a true and correct extract from the employment and payroll record(s), of which I have legal custody:

Employer's Representative: Rose Rufo Job Title: Controller

Signature: [signature] Phone: 266-7000 Date Prepared: 4/11/16

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