



JOHNS HOPKINS

M E D I C I N E

I N T R A S T A F F

EDUCATIONAL VERIFICATION FORM

A former student, _____, SSN# _____, has
(print name-maiden)
applied for a position with our organization. We are asking that you furnish us with the following information.

High School Name _____ Address _____

City _____ State _____ Zip Code _____

Birthdate _____ Year Graduated _____

Signature _____ Date _____

-----Completed by Institution-----

Graduated: _____

High School: _____

Signature: _____ Date: _____

GED VERIFICATION

Print Name _____ SSN# _____

GED Certificate by _____ Date Received _____

I, _____, give authorization for *Intrastaff* to receive education verification on the above.

Signature _____ Date _____

Please fax completed form to Intrastaff at (410) 847-3659

*2330 W. Joppa Road, Foxleigh Building Suite 395 * Lutherville, MD 21093 * (410) 583-2950*