



## VERIFICATION OF EMPLOYMENT FORM

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Company's Business Name: \_\_\_\_\_

Address: \_\_\_\_\_

**I HEREBY AUTHORIZE MY EMPLOYER TO PROVIDE THE INFORMATION REQUESTED BELOW**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***The employee named above or his/her family member has applied for a Sliding Fee Discount for discounted fees for medical and/or dental services at HealthWorks. The information below is required for determination of eligibility for discounted services.***

Job Title: \_\_\_\_\_

If no longer employed, last date employee worked: \_\_\_\_\_

Employee is:  Full-time  Part-time  Temporary

How often is this employee paid:  Daily  Weekly  Bi-weekly  Monthly  Other

How much is this employee paid per hour? \_\_\_\_\_

Average number of hours worked weekly: \_\_\_\_\_

Does this employee receive tips? \_\_\_\_\_ If yes, average tips per week: \_\_\_\_\_

\_\_\_\_\_  
Name of Person Completing Form Job Title

\_\_\_\_\_  
Signature Date Phone Number

### FOR OFFICE USE

Pay Date:				
Gross Earnings:				