HealthWorks for Northern Virginia
Your Community Health Center
Compassionate • Culturally Competent • Accessible to All

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:				