

Wage Verification Letter



To be completed by the employee:

Employee Name: _____ Social Security #: _____

Employee Address: _____ Apt. _____
Street

(City) (State) (Zip) Telephone #: _____

I hereby authorize the employer listed below to release the requested information regarding my income and employment status to San José Clinic.

Employee Signature

Date

To be completed by the employer:

To Whom It May Concern:

Your employer (or member of his/her family) listed above, has applied for services at San José Clinic. To determine eligibility for these services we need verification of his/her gross income and employment status. With your employee's written authorization please provide us with the information listed below.

Company Name: _____

Employer's Name: _____

Employer's Address: _____

(City) (State) (Zip) Telephone #: _____

Employee's Occupation: _____ Date of Hire: _____

Gross Salary: \$ _____ Annual ___ Monthly ___ Bi-Weekly ___ Weekly
(Check One)

Hourly Wage: \$ _____ Number of hours worked per week: _____

Insurance Coverage (please circle): Employee: Yes No Family: Yes No

If the employee is no longer employed or on Leave of Absence, please indicate the last day of work:

(Date)

Person providing this information (Please print): _____

Signature Title Date

PLEASE ATTACH A BUSINESS CARD OF THE COMPANY.