EMPLOYMENT VERIFICATION FORM

Return completed form to Community Health Centers, Inc.

EMPLOYEE'S NAME: _____

COMPANY'S BUSINESS NAME: _____

ADDRESS: _____

PHONE #: _____

The employee named above or his/her family member has applied for a Sliding Scale Plan for discounted fees for medical and/or dental services at our facility. The information below is required for determination of eligibility for discounted services.

I HEREBY AUTHORIZE MY EMPLOYER TO RELEASE THE INFORMATION REQUESTED BELOW:

_____ _____
Employee Signature Date

1. Job Title: _____
2. Is Employee: ____Full-Time ____ Part-Time _____Temporary
3. Is Employee paid: ____Weekly ____Daily ____Bi-Weekly ____Other
4. Does Employee receive over-time? ____Yes ____No
   If the answer is yes, is this received: ____Regularly ____Occasionally
5. Is Employee covered with group health insurance? ____Yes ____No
   If this answer is yes, name of insurance: _____
   Does Employee have dependent coverage? ____Yes ____No

RECORD OF PAY RECEIVED FOR PAST 4 WEEKS:

Pay Period Dates	Gross Earnings	Hours Worked

Name of Person completing form: _____

Title of Person completing form: _____

Rev'd 09.14.07