Employment Verification Form

Employee Name: _____ Social Security Number: _____

The above named person has applied for the sliding scale fee at Pediatric Associates of Watertown, PC. To determine eligibility for the person/family, all earnings must be verified.

THIS SECTION MUST BE FILLED OUT BY EMPLOYER IN INK:

1. Is the person named above employed by you? _____ (Yes) _____ (No) Date hired: _____

   Give total gross income for previous year if worked: _____

   Estimated length of employment since first hired (Months) (Years) _____

   Date terminated (if applicable) _____.

   If employee is or has been on leave of absence, give date leave began: _____

   Date of expected return: _____.

   Is the employee seasonal? ___(Yes) ___ (No)

   If yes, give current year total income:_____& if applicable, Contracted hours_____

2. How often is the employee paid? ___weekly ___every 2 weeks ____ monthly _____twice monthly.

   Average number of hours worked per week. _____.

3. Please state hourly wage: _____.

4. Are any changes expected in employee's pay or status during the next six months?

   If yes, please explain: _____.

5. On the chart below, please state all earnings for the last four (4) weeks:

   PLEASE INDICATE EARNINGS BEFORE DEDUCTIONS

   DATE PAID GROSS AMOUNT

   1. _____
   2. _____
   3. _____

Does the employee have health insurance? _____ (Yes) _____(No)

If yes, please fill in the information below:

Name of insurance company _____.

Policy Number _____.

Group Number _____.

Effective Date _____.

Name(s) of insured dependents: _____.

Name of person representing the employer: _____ Date: _____

I authorize my employer, _____ to release wage information to PAW.

_____ _____

SIGNATURE OF PATIENT/EMPLOYEE DATE