Wage Verification Letter

TOMAGWA
Healthcare Ministries

To be completed by the employee:

Employee Name: ___________________________________ Social Security #: ___________________

Employee Address: ____Apt. ____________________

Street

____Telephone #: __________________

(City) (State) (Zip)

I hereby authorize the employer listed below to release the requested information regarding my income and employment status to Tomagwa HealthCare Ministries.

____ ________________________________

Employee Signature Date

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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 Tomagwa HealthCare Ministries. 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.