Verification of Earnings Form

Dear Employer:

An employee of your company has applied for the Access Assistance (Discount Program) at Dr. Kockler's office. Please complete this form and return it to the employee. Thank you for your cooperation.

Name of Employee:____

Address:____

Number & Street/PO Box City State Zip

Social Security Number:________-________-_________

It is hereby certified that the individual named above is employed by the undersigned, and that the following wages and hours represent a normal rate of this individual.

Number of hours worked per week (average):____

Average Gross Weekly Income $:____

Signature of Employer Representative:____

Name of Employer:____

Address:____

Number & Street/PO Box City State Zip

Telephone Number: (_______)___________-_____________

Does the employee have health insurance coverage?_____________yes________________no

PERMISSION TO RELEASE WAGE/INSURANCE INFORMATION:

____

Signature Date