CASH INCOME STATEMENT

FAUQUIER FREE CLINIC
35 Rock Pointe Ln, Warrenton, VA 20186
P.O. Box 3138, Warrenton, VA 20188
edocs@fauquierfreeclinic.org

PATIENT (Please Print)

First Name	Last Name
Cell Phone	Home Phone

Please enter your Income for the last 4 Weeks

Week 1: $ ______________

Week 2: $ ______________

Week 3: $ ______________

Week 4: $ ______________

TOTAL for the Month: $ ______________

I was paid: ______ By the hour ______ By the day

I was paid: ______ In cash ______ By check

I certify that the information above is true and correct, and to the best of my knowledge. I understand that false information or omissions are grounds for dismissal from the Fauquier Free Clinic and all its services.

PATIENT Signature: ____ Date: ____________