VERIFICATION OF EMPLOYMENT

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

EMPLOYER: The following information is CONFIDENTIAL and for the use of the Fauquier Free Clinic ONLY.
To receive primary Medical, Dental and Mental Health services at the Fauquier Free Clinic, your Employee must have proof of their income. The information you provide will be used to verify their eligibility for Clinic services. We appreciate your completing this form on your Employee's behalf.

EMPLOYEE Information

Employee Name: ____

Employee Status: ________ **Full Time** _________ **Part Time**

Employee is Paid: ______ **Weekly** ______ **Bi-Weekly** _____ **Monthly**

Hourly rate of Pay: $ ___________ **Average number of Hours a week** __________

By the DAY Only: Set Amount $ ____________ **Average # of Days a week** ________

If Employee is a SEASONAL WORKER, circle the months that the employee's hours are reduced:

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Average Number of hours worked per week during these months _____________

EMPLOYER Information

Employer Name : ____

Company Name: ____
(if applicable)

Employer Address: ____

Employer Phone Number: ____

Employer Signature: ______________________________ **Date:** _____________