



Partners Together in Healthcare

## EMPLOYMENT VERIFICATION FORM

Return completed form to **Premier Community HealthCare Group, Inc.**

EMPLOYEE'S NAME: \_\_\_\_\_

COMPANY'S BUSINESS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

The employee named above or his/her family member has applied for discounted fees for medical and/or dental services at our facility. The information below is required for determination of eligibility for discounted fees.

I HEREBY AUTHORIZE MY EMPLOYER TO RELEASE THE INFORMATION REQUESTED BELOW:

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

1. Job Title: \_\_\_\_\_
2. Is Employee:  Full-Time  Part-Time  Temporary
3. Is Employee paid:  Weekly  Daily  Bi-Weekly  Other
4. Does Employee receive over-time?  Yes  No  
If the answer is yes, is this received:  Regularly  Occasionally
5. Is Employee covered with group health insurance?  Yes  No  
If this answer is yes, name of insurance: \_\_\_\_\_  
Does Employee have dependent coverage?  Yes  No

### RECORD OF PAY RECEIVED FOR PAST 4 WEEKS:

Pay Period Dates	Gross Earnings	Hours Worked

Name of Person completing form: \_\_\_\_\_

Title of Person completing form: \_\_\_\_\_

Date form completed: \_\_\_\_\_