To be completed by employer when employee doesn't receive paystubs.

Employer Statement of Income

For Employer Use Only

Employee Information

_____, who resides:
(Name of Employee)

_____
Employee's Physical Address)

Currently works for me doing _____.
(Type of Work Employee Does for Payment)

He/She is paid the Gross amount of: $_____ on a **weekly / bi-weekly / monthly / hourly** basis.
(circle one)

He/She normally works: _____ hours per week.
(Number of Hours Worked)

He/She received tips (if applicable) in the amount of $_____ for the last 2 weeks.

Employer Information

By my signature, I attest that all information listed above is accurate and the employee does not have health insurance through me or the company.

_____ _____
Signature of Employer Date

_____
Printed Name of Employer

_____ _____
Company Name (if applicable) Employer Contact Number

_____
Employer Physical Address City State Zip

NOTE: The employer must sign this statement and completed form must accompany Medication Assistance Pharmacy application.