ILIULIUK FAMILY AND HEALTH SERVICES, INC.
P.O. Box 144, Unalaska, AK 99685
Telephone: 907-581-1202 Facsimile: 907-581-2331

Employment Verification Form

Employee Name: _____ Social Security Number: _____

The above named person has applied for the sliding scale fee at the clinic. To determine eligibility for the person/family, all earnings must be verified.

THIS SECTION MUST BE FILLED OUT BY EMPLOYER IN INK:

1. Is the person named above employed by you? _____ (Yes) _____ (No) Date hired: _____
   Give total gross income for previous year if worked: _____
   Estimated length of employment since first hired (Months) (Years) _____
   Date terminated (if applicable) _____.
   If employee is or has been on leave of absence, give date leave began: _____
   Date of expected return: _____. Is employee seasonal? ___(Yes) ___ (No)
   If yes, give current year total income:_____& if applicable, Contracted hours_____

2. How often is employee paid? ___weekly ___every 2 weeks ____ monthly _____twice monthly.
   Average number of hours worked per week. _____.

3. Please state hourly wage: _____.

4. Are any changes expected in employee's pay or status during the next six months?
   If yes, please explain: _____.

5. On the chart below, please state all earnings for the last four (4) weeks:
   PLEASE INDICATE EARNINGS BEFORE DEDUCTIONS
   DATE PAID GROSS AMOUNT
   1. _____
   2. _____
   3. _____

Does the employee have health insurance? _____ (Yes) _____(No)
If yes please fill in the information below:
Name of insurance company _____.
Policy Number _____.
Group Number _____.
Effective Date _____.
Name(s) of insured dependents: _____.

Name of person representing the employer: _____ Date: _____

I authorize my employer, _____ to release wage information to IFHS.

_____ _____
SIGNATURE OF PATIENT/EMPLOYEE **DATE**