Employment Verification Request

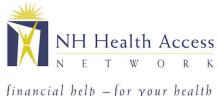
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Name of Emplo	yee:	Social Security#:	

We would appreciate employment and wage information concerning the employee named above. This is necessary in order to determine his/her eligibility for benefits. Thank you for your cooperation.

Financial Assistance Program Monadnock Community Hospital 452 Old Street Rd Peterborough, NH 03458

Phone: (603) 924-1717 Fax: (603) 924-1709





Fax: (603) 924-1709	COMMUNITY HOSPITAL financial help - for your health
Employee's Job Title:	
Beginning Date of Current Employment:	
Average hours per week:	If temporary, until:
Please list Gross wages, bonuses, tips, c	ommission, etc.
Current Rate of Pay: \$ per	Effective pay period ending:
Frequency of Pay: (circle one) Weekly	Bi-Weekly Monthly Other:
Actual Date first paycheck received:	
Please indicate if the employee has any o	of the following items through his/her employment:
	Savings bond(s)Shares/Profit SharingShares/Profit Shares/Profit Shares/Profi
Do you anticipate any upcoming change	in the number of hours worked or the rate of pay?
Please complete for at least 3 full weeks	:
Actual Date Paid Gross	Pay Actual Date Paid Gross Pay
Signature:	Date: