EMPLOYMENT VERIFICATION REQUEST

Financial Assistance
PO Box 678, Laconia, NH 03247
Tel: 603-527-7171 Fax: 603-527-7038

To: _____

_____

_____

Lakes Region General Hospital 603-524-3211

Franklin Regional Hospital 603-934-2060

Name of Employee _____ Employee Social Security # _____

Signature of Employee _____ Date _____

We would appreciate employment and wage information regarding the employee named above. This is necessary in order to determine his/her eligibility for benefits provided through our Financial Assistance Program.
Please provide the information requested below and return to the above address.

Employee job title _____

Beginning date of current employment _____

Average hours worked per week _____

If temporary, until _____

Current rate of pay _____

Effective pay period ending _____

Frequency of pay (circle one)

Weekly Bi-Weekly Semi-Monthly Monthly

Other (explain) _____

Indicate if the employee has access to any of the following benefits through his/her employment (Check all that apply)

____ Credit Union Account(s) ___Savings Bonds

____ Share/Profit Sharing ___ Medical Insurance

____ Retirement Fund/IRA

____ Mandatory Wage Assessment (please specify)

Please list gross wages, bonuses, tips, commissions etc.

Pay Period	Actual Date Paid	Gross Pay

_____
Signature/title of person providing information

Date Telephone