CLEVELAND AVENUE DENTAL CENTER

Forsyth County Department of Public Health

WAGE VERIFICATION FORM

I hereby authorize my employer to release the following information to the Forsyth County Department of Public Health.

_____

Client signature Date

The following should be completed by the employer.

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Employee's Name: _____

Start Date: _____

Gross Salary: _____ Hourly Rate: _____

Pay period: _____ Frequency: _____

If irregular schedule: Average hours worked per week _____

Average weeks worked per year _____

Comments: _____

Employer Signature: _____

Title: _____ Date: _____

This form should be completed within the next 30 days. Date: _____