



MUSC/CMH/UMA EMPLOYEE VERIFICATION STATEMENT

Charleston Memorial Hospital
University Medical Associates

I, _____ hereby authorize and request my employer, _____
(Print Applicant's Name) (Print Business Name)

to release information regarding my wages and employment.

Signature of Applicant Date Social Security Number

EMPLOYER MUST FILL IN INFORMATION BELOW (PROVIDE AT LEAST ONE (1) MONTH'S PAY INFORMATION)

Employee paid Weekly Bi-Weekly Monthly Twice Per Month Other

Date Employment began _____

Payroll Ending Date	Date Paid	Hours Worked Per Pay Period	Gross Pay (Include Tips, Gratuities, etc)

PRINT NAME OF PERSON COMPLETING FORM/TITLE/DATE

SIGNATURE OF PERSON COMPLETING FORM

PRINT BUSINESS NAME/ TELEPHONE NUMBER

ADDRESS OF BUSINESS

COPIES OF DOCUMENTS MUST BE SUBMITTED WITH APPLICATION OF ALL THAT APPLY