To be completed by the employee:

Employee Name: _____ Social Security #: _____

Employee Address: _____ City, St, & Zip _____

I hereby authorize the employer listed below to release the requested information regarding my income and employment status to UF & Shands Healthcare.

_____ _____

Employee Signature Date

To be completed by the employer

To Whom It May Concern:

Your employee (or member of his/her family) listed above, has applied for services at UF Health. To determine eligibility for assistance for services that were rendered, we need verification of his/her gross income and employment status. With your employee's written authorization please provide us with the information listed below.

Company Name: _____

Employer's Name: _____

Employer's Address: _____

Date of Hire: _____ Telephone #: (_____)_____

Year to Date Gross: $_____ as of (date): _____

If the employee is no longer employed or on Leave of Absence, please indicate the last day of work:_____

Person providing this information (Please print): _____

Employer's Signature: _____

Title:_____ Date: _____

IF POSSIBLE, PLEASE ATTACH A BUSINESS CARD / STAMP OF THE COMPANY.

In accordance with public law s.817.50 F.S., providing false information to defraud a hospital for the purposes of obtaining goods or service is a misdemeanor in the second (2nd) degree.