KIAMICHI
FAMILY MEDICAL CENTER

SLIDING FEE PROGRAM
PO Box 180
Battiest, OK 74722
(580)241-5294
(580)241-5739 FAX
www.kiamichimed.org

STATEMENT FROM EMPLOYER

Date: _____

To Whom It May Concern:

Your employee, _____, is applying for our Sliding Fee Program (to help with medical expenses). In order to process his/her application, we must have proof of their last two month's gross income.

Therefore, please advise us of how much he/she makes per hour, and approximately how many hours he/she works per week.

$_____per hour x _____hours per week (approximately)

OR, if the above isn't practical for your type of business, then please complete the following:

GROSS EARNINGS for last/previous month:

Month: _____20___ $_____

Name of Employer: _____

Direct Supervisor: _____

Address: _____

Phone: _____

Employer's Signature:_____ Date:_____