



# RURAL HEALTH SERVICES, INC.

## WORK STATEMENT VERIFICATION FORM

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DATE OF REGISTRATION:   /   /    
M M D D Y Y

The bearer of this note \_\_\_\_\_, is a  
(EL portador de esta nota es un- escribir nombre de la persona arriba)

Worker at/in the home of (trabaja en/vive en la casa de \_\_\_\_\_),

located at (situado en):

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

He/She receives payment of (EL, Ella reciben un pago de)  \$

- Daily (Diaro)
- Weekly (Semanal)
- Bi-Weekly (Quincenal)
- Monthly (Mensual)

Printed Name of Employer (Nombre Escrito del Empleador):

Signature of Employer (Firma de Empleador):

Printed Name of Employee (Nombre Escrito del Empleado):

Signature of Employee (Firma de Empleado):