INOVA

Financial Assistance Office
8095 Innovation Park Drive
Fairfax, VA 22031

Verification of Employment

APPLICANT: This form is to be completed by the person who is verifying income on your behalf. This document does not assign to you, any financial responsibility of outstanding medical debt due from the patient who is applying for financial assistance.

The person requesting completion of this form has requested financial assistance from Inova Health System associated with services provided. This information is necessary to complete the eligibility review.

Guarantor/MRN: _____
Employee Name: _____

The frequency of Pay: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Wages: _____

Company Name: _____
Company Address: _____
_____
Phone number: _____
Title/ Position: _____

Employer Attestation:
I certify that to the best of my knowledge, the above information is true and correct.
I agree that you may contact me if further verification is necessary.

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Signature of Person Completing This Form Date Signed

This Form Must Be Notarized:

I, the undersigned Notary Public, certify that this document was signed before me in the City/County of _____on this _____ day of_____, 20_____.

_____
Notary Public

My commission Expires: _____