

VERIFICATION OF EMPLOYMENT
AUTHORIZATION FORM

I _____ hereby authorize Community Clinic, Inc. (CCI) to release the following information:

- Social Security Number
- Title and Salary
- Current Address
- Gross Earnings To-Date

TO:

COMPANY NAME: _____

ADDRESS: _____

I understand the risks associated with such information being provided to the above listed party and understand that such information will be honest, accurate and consistent. Community Clinic, Inc. (CCI) will provide me with a copy of any details provided. I further understand that the information requested will be completed and handed over to me directly and no other individual associated with the above party.

Signature of Applicant or Employee

Date

Printed Name of Applicant or Employee

Your request will be completed within 24-48hrs. of receipt.

