COMMUNITY HEALTH AND DENTAL CARE

Healthcare Discount Application

Self-Employment Form

Patient's Name: _____

Date: _____

To Whom it May Concern:

I, _____ the undersigned residing at
(name)

_____ certify that I am self-employed at the
(address)

following jobs:

_____

_____

I attest that (based upon the attached documentation, i.e. receipts for services rendered, income tax returns, etc.) the following is the approximate amount of income that I receive monthly $ _____, or annually $ _____.

_____ _____

Signature Date of Birth

_____ _____

Print Name Social Security Number