



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