

WORKERS COMPENSATION VERIFICATION

THIS SECTION TO BE COMPLETED BY TENANT AND EXECUTED BY MANAGEMENT

TO: _____
Employer [company] Name & Address

Phone Number Fax Number

RE: _____
Applicant/Tenant Name

Social Security Number

Unit # (if assigned)

I hereby authorize release of my workers compensation information.

Signature of Applicant/Tenant Date

The individual named directly above has indicated that he or she is receiving payment for you and is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy. Your prompt response is crucial and greatly appreciated.

Signature of Owner's Representative Date

Return Form To:

THIS SECTION TO BE COMPLETED BY APPROPRIATE AGENCY

Weekly Monthly Payments to Employee \$ _____

Weeks or amount still to be paid _____

Effective Date _____ Ending Date, if known _____

Additional Remarks: (please indicate any anticipated changes.) _____

Signature Printed Name & Title Date

Agency's Name and Address

Phone # Fax # E-mail

NOTE: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.