CLINCH RIVER HEALTH SERVICES

SLIDING FEE PROGRAM
17285 Veterans Memorial Hwy
Dungannon, VA 24245
276/467-2201
276/467-2673

Self Employed Proof of Income

Business Name: _____

Business Owner(s): _____

Business Address: _____

Business Phone: _____

Brief Description of Business: _____

_____

_____

Last/Previous Month's GROSS Earnings (FOR THE BUSINESS OWNER = what you paid yourself, *NOT* the business gross):

Month/Year: _____20____ $_____

_____/_____

Signature of Business Owner Date