Maternal & Family Health Services

15 Public Square, Suite 600,
Wilkes-Barre, PA 18701
800.367.6347
mfhs.org

Verification of Cash Employment

Employer's Name_____
Employer's Phone _____
If possible:
Employer's
Street Address _____
City, State, Zip _____

To whom it may concern:

This is a request to verify the employment of :
(Enter Individuals Name)_____ regarding their eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

You are asked to keep this inquiry confidential.

Please complete the bottom portion and return the entire letter to your local WIC Center.

Thank you for your cooperation.

Sincerely,

WIC Program

Date of employment:_____ to _____.

Salary: $_____ per _____*

*If you are providing hourly wage, please list the number of hours per week the individual works:_____.

_____ _____

Signature & Title of Employer's Representative Date