



Metro Community
Provider Network

MCPN's Mission:
To provide excellent health-related services
focusing on the underserved.

Care To Make a Difference

MCPN FINANCIAL EMPLOYMENT LETTER

*(This letter needs to be completed and signed by your employer,
NOT by you.)*

I, _____, gave MCPN permission to request the following information.

Applicant's Signature: _____ ***Date:*** _____

Company Name: _____

Company
Address: _____

City: _____ State: _____ Zip: _____

Supervisor Name: _____ Title: _____

Date of Hire: _____

Hourly Wage/Salary: _____ Hours Worked Per Week: _____

Pay Period (***please circle***) Weekly, Bi-Weekly, Semi-Monthly, Monthly

Gross Income for Previous Month: _____ Amount: \$ _____

Employer Signature: _____ ***Date:*** _____

Telephone Number: _____

Thank you for your cooperation!