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: ______________________________________

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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