Division of Public Health F-40076 (Revised 01/05)

## WOMEN, INFANTS, AND CHILDREN (WIC) NUTRITION PROGRAM INCOME STATEMENT

## Employee:

Employer:

Completion of this form is voluntary. It will be used only by the WIC Program for proof of income for employees who do not receive a paycheck stub. Proof of income is needed for enrollment in the WIC Program.

Please complete the following and return the original form to the employee.	
Employee Name	
Gross Income (The most current income i	s needed)
Date this income was provided:	
hourly wage hours per week	OR weekly income
Employer: Name of Business	
Address	
Telephone	
By signing my name, I acknowledge that the information I have given is correct, to the best of my knowledge.	
Employer Printed Name	
Employer Signature	Date Signed

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