

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

Employee:

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.

Employer:

Please complete the following and return the original form to the employee.

Employee Name \_\_\_\_\_

Gross Income (The most current income is needed) \_\_\_\_\_

Date this income was provided: \_\_\_\_\_

_____ hourly wage
_____ hours per week

OR

_____ weekly income
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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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