DECLARATION OF INCOME

Date: _____

I, _____certify by my signature that I
(First and Last Name)

am self-employed in the following type of work: _____
(Specify the type of work you do)

I certify that my total income in the last 4 weeks was $_____
(Total income includes earned and unearned)

The undersigned represents that they have no health insurance or any other payor source for the healthcare services for which application for St. John Bosco Clinic is being completed.

The undersigned further represents that they have been continuously residing in the United States since _____(Month) _____(Year).

The undersigned also represents that the information provided in this application is true and correct in all material respects. If my situation changes I am responsible to notify St. John Bosco Clinic immediately. I understand that if any of the above information was false at the time I completed this form, or if I fail to notify the Clinic of any changes, St. John Bosco Clinic has the right to discharge me as a patient of the Clinic.

_____
Applicant's Signature

STATE OF FLORIDA

County of _____

The foregoing instrument was acknowledged before me this _____day of _____,

20_____ by _____ , who is ❒personally known to me or ❒who has

produced _____ as identification.

_____ _____
Notary Signature Notary Stamp

Rev. 3.14.18, 1.26.21, 3.17.21, 7.30.21