

CHILD CARE INCLUSION PROGRAM VERIFICATION OF WAGES AND BENEFITS

Section A: Child Care Service Information

Operating Name			
Street Address			
City/Town		Province NL	Postal Code

Section B: Vendor Information

Vendor Name			
Vendor Number		Service Authorization Number	

Same as Operating Address

Street Address			
City/Town		Province NL	Postal Code

Section C: Wage Information (attach required documentation)

Funded Staff Person Name:	
Pay Period: From YYYY/MM/DD:	To YYYY/MM/DD:
Hourly Rate:	Employer's CPP
Hours Worked:	Employer's EI
Hours Worked in Inclusion:	Workers Compensation
Gross Pay	Other ¹ (specify benefit below)
Vacation Pay (%)	
Total	
	Total Claimed

¹ Other benefits must be identified in the space provided, verified via submitted documentation and deemed eligible.

Signature

I, the undersigned, do hereby certify that all of the information provided on this form, and supporting documentation, is accurate and true to the best of my knowledge.

Licensee/FCC Provider or
Authorized Designate (please print)

Signature

Date YYYY/MM/DD

Funded Staff Person (please print)

Signature

Date YYYY/MM/DD

For Office Use Only