



STATEMENT OF COMPLIANCE

(Certified Under Penalty of Perjury)

CONTRACTOR: _____

PAYROLL PERIOD: _____ to _____
First Day of Pay Period Last Day of Pay Period

I, _____, the undersigned, am
(Name - print)

_____ with the authority* to act for and on behalf
(Position in business)

of _____,
(Name of business and/or contractor)

certify under penalty of perjury that the records or copies thereof submitted and consisting of

_____ are the originals or true, full and
(description / no. of pages)

correct copies of the originals which depict the payroll record(s) of the actual disbursements

by way of cash, check, or whatever form to the individual or individuals named.

*Must be signed by the owner
or other person holding
interest in the firm.

Signature: _____

Title: _____

Date: _____

☐ A. MEDICAL BENEFITS ARE PAID INTO APPROVED PLANS, FUNDS OR PROGRAMS.

☐ B. MEDICAL BENEFITS ARE NOT PROVIDED