# 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