

WAGE LOSS VERIFICATION

DATE \_\_\_\_\_

TO THE EMPLOYER:

This statement is for the benefit of your employee in his or her claim arising out of an accident THAT IS IN NO WAY CONNECTED WITH HIS OR HER EMPLOYMENT AT YOUR COMPANY. It will be to your employee's advantage if this form is filled out completely.

NAME OF EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

NAME OF EMPLOYEE: \_\_\_\_\_

SOCIAL SECURITY NO. : \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

DATE EMPLOYED: \_\_\_\_\_

TIME LOST FROM WORK : FROM \_\_\_\_\_ TO \_\_\_\_\_

SALARY: \$ \_\_\_\_\_ PER \_\_\_\_\_

HOURS WORKED PER WEEK: \_\_\_\_\_

BONUS, COMMISSION OR OVERTIME LOST, IF ANY : \$ \_\_\_\_\_

EMPLOYEE'S REGULAR DUTIES:

COMMENTS:

SIGNED \_\_\_\_\_

OFFICIAL TITLE \_\_\_\_\_

TELEPHONE \_\_\_\_\_

