Dear _____:

I represent _____ concerning injuries _____ suffered in an automobile accident that occurred on the _____ day of _____, 20___. I am seeking verification of _____'s employment, rate of pay, and any loss of wages that resulted from the injuries suffered, whether due to recovery time or subsequent medical treatment. Please complete the form at the bottom of this page and return it to my office at the above address.

If you have any questions do not hesitate to call. Thank you for your cooperation in this matter.

Sincerely yours,

_____

WAGE STATEMENT

I, _____ , certify that _____ was employed by _____ on the ___ day of _____ , 20 __ , and that the following information concerning his/her employment record is true and correct.

COMPANY NAME AND ADDRESS _____
POSITION OF EMPLOYMENT _____
RATE OF PAY $ _____ PER _____ SALARY $ _____ PER _____
NORMAL HOURS PER DAY _____ PER PAY PERIOD _____
DATES OF DAYS MISSED _____

BY _____ TITLE _____
DATE _____