# EMPLOYMENT VERIFICATION FORM

## THIS FORM IS TO BE COMPLETED BY THE VICTIM'S EMPLOYER

CVR NUMBER:

VICTIM:
VICTIM SSN:
CLAIMANT:
ADDRESS:

DATE OF CRIME:

**CLAIMANT INSTRUCTIONS:**
1) Ask the victim's employer to complete and return this form to you.
2) Give completed form to your claim investigator.

**EMPLOYER INSTRUCTIONS**:
1) A claim is being made for wages lost as a result of an injury of the victim referenced to the left, and caused by a crime on the date shown.
2) Complete this form, verifying the actual earnings lost and return to the claimant.

Name of Business: _____ Victim's Job Title: _____

Business Address _____ Victim's Supervisor _____

_____ Phone No.: ( ) _____

Victim employed: [ ] FULL TIME [ ]PART TIME [ ]OTHER HOW LONG EMPLOYED? _____ (Years/Months)

Victim absent from work**: FROM**: _____/_____/_____ **TO:** _____/_____/_____ = _____
Total weeks out of work

Date returned to work: _____/_____/_____ [ ] Did not return to work

## INCOME/EARNINGS CALCULATION

WKLY INCOME: $_____ RATE OF PAY: $ _____ per [ ]Hr [ ]Wkly [ ]Monthly ____ [ ]Other _____

How many days does employee work a week?_____How many hours does employee work each day?_____

OVERTIME/COMMISSION: $_____

Was employee paid for time off from work? [ ] Yes [ ] No DISABILITY INCOME : $ _____

WORKMEN'S COMP: $_____ BEGINNING DATE _____ ENDING DATE _____

LOST WAGE INCOME: $ _____ X _____ = $ _____
Wkly Income Wks/Out of Wk

( $ _____) (Less: Wkrs. Comp. or Social Security)

= $_____ **Lost Wages** (Adjusted)

## VERIFYING SIGNATURE

_____ _____
AUTHORIZED SIGNATURE DATE

_____ (____)_____
PRINTED NAME PHONE

_____
TITLE