Wage Verification Form

Employee: ________________________ (DOB: __________________)

Date of Loss: ________________________

Job Title: ____

[customize for claimant & incident, not always MVA]

- Ms. Jones has been employed with our company since _____________.
- On the date of the accident, she was paid as follows: $ _______________ per hour - week - month (circle one).
- On the date of the accident, she worked approximately _____________ hours per day - week - months (circle one).
- Due to the [date] injury, she has missed work (including vacation time or sick leave) on the following dates at the following rates of pay:

  Dates: _________________________ Rate of Pay: _________________

  Dates: _________________________ Rate of Pay: _________________

  Dates: _________________________ Rate of Pay: _________________

- She has missed ____________ (circle one) hours - days - weeks - months, including vacation time or sick leave, of work due to this collision.

As of today, Ms. Jones has lost a total of $ ___________________ in gross wages due to this collision, including calculated sick leave and vacation time traceable to this collision.

Signed this ____________day of ______________, 2011.

Signature: ____

Printed Name: ____

Job Title: ____

Company Name: ____

Company Telephone: ____

Company Address: ____