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: _____