

**VERIFICATION OF LOST WAGES**

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NO. \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

DATE OF INJURY/ACCIDENT: \_\_\_\_\_

1. As of the date of injury, \_\_\_\_\_ was being paid a gross salary of  
\$ \_\_\_\_\_ per \_\_\_\_\_ HOUR \_\_\_\_\_ DAY \_\_\_\_\_ WEEK \_\_\_\_\_ YEAR

2. As of the date of injury, \_\_\_\_\_ was working an average of  
\_\_\_\_\_ hours day, \_\_\_\_\_ days per week.

3. Because of \_\_\_\_\_ injury, \_\_\_\_\_ did not work following the  
injury until \_\_\_\_\_ returned to work on \_\_\_\_\_.

4. \_\_\_\_\_ has been absent from work as a result of these injuries for a  
total of: \_\_\_\_\_ hours \_\_\_\_\_ days \_\_\_\_\_ week.

5. \_\_\_\_\_ lost his/her job with this employer.

6. \_\_\_\_\_ has lost or is no longer eligible for the following company benefits:

_____	Health Insurance	Value: \$ _____
_____	Dental Insurance	Value: \$ _____
_____	Vacation Time	Value: \$ _____
_____	Other _____	Value: \$ _____

7. Total wages lost as a result of the accident of \_\_\_\_\_:

\$ \_\_\_\_\_.

Date: \_\_\_\_\_

\_\_\_\_\_  
SUPERVISOR SIGNATURE

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title