

WAGE AND SALARY VERIFICATION

Employee's Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

1. Occupation: _____

2. Dates of employment: From: _____ Through: _____

3. Earnings during 52-week period to accident: \$ _____ Gross \$ _____ Net

Wages or salary as of date of accident: \$ _____ ☐ Per Hour ☐ Per Week ☐ Per Month

Number of hours worked: _____ Per Day _____ Per Week

Number of days worked: _____ Per Week

Circle specific days employee is scheduled to work: SU M T W TH F S

4. Dates(s) absent following accident: From: _____ Through: _____

5. Are you a covered employer for:

a. State Temporary Disability ☐ Yes ☐ No ☐ N/A

b. Private Disability Plan ☐ Yes ☐ No ☐ N/A

If yes, has the employee filed for benefits under a or b above? ☐ Yes ☐ No ☐ Undetermined

Name of the Insurer/Disability Plan: _____

What weekly disability income benefits, if any, are provided? _____

6. Total accumulated days: Sick _____ Vacation _____ Personal _____

Are the above days required to be used before becoming eligible for the applicable disability plan?

☐ Yes ☐ No

7. Has or will a claim be filed under any workers' compensation law for this accident?

☐ Yes ☐ No ☐ Undetermined

If yes, please provide the workers' compensation carrier's:

Name and Address: _____

Policy Number: _____

Phone Number: _____

Any person who knowingly provides false or misleading information may be subject to criminal and civil penalties.

DATE: _____ SIGNED: _____

TITLE: _____