Employee Wage Verification Form

Employee's name:_____

Employer:_____

Employer's address:_____

Employer's phone no.:_____

Date of accident:_____

Occupation:_____

Dates of employment: from_____ to _____

Wage or salary as of date of incident: $_____
( ) per week ( ) per hour ( ) per day ( ) per month

Tips or other supplemental income: $_____
( ) per week ( ) per hour ( ) per day ( ) per month

Usual number of days worked per week:_____

Usual number of hours worked per week:_____

Dates absent following incident
Date disability began:_____ Date returned to work:_____

Has employee been paid during absence? Yes( ) No( )

Sick leave: $_____

Annual leave: $_____

Other: $_____

Signed:_____ Date:_____

Title_____