WAGE & SALARY VERIFICATION

________________ ________________________ ___________________
Date Date of Accident File No.

EMPLOYER'S NAME: **EMPLOYEE'S NAME & ADDRESS:**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

1. ________________________
Occupation

2. Dates of Employment: From: _____________ To: _____________

3. Wage/Salary As Of Date of Accident:

$_____Per Hour $_____Per Week $___________Monthly

4. Number of Days Worked Per Week:_____________ Hours Per Day___________

5. Has Employee Filed A Claim For Benefits Under Any Workmen's Compensation Or Similar Law As A Result Of This Accident? ______ ______
YES NO

6. Has Employee Received, Is He/She Receiving Or Is He/She Entitled To Receive Benefits Under Any Workmen's Compensation Or Similar Law As A Result Of This Accident?

______ ______ ____________
YES NO UNKNOWN

7. Dates Absent Following Accident:

Date Disability Began:____________; Date Returned To Work:_________

EMPLOYER SECTION

Date: _________________________

Signed: _________________________ Title: _________________________

Telephone: _________________________

Address: ____