WAGE AND SALARY VERIFICATION

___________	___________________	___________
DATE	**DATE OF ACCIDENT**	**FILE NO.**

EMPLOYER'S NAME & ADDRESS: ________________________________ ________________________________ ________________________________ ________________________________

EMPLOYEE'S NAME & ADDRESS: ________________________________ ________________________________ ________________________________ ________________________________

1. **OCCUPATION:** ____

2. **DATES OF EMPLOYMENT: FROM:** _______________ **TO:**________________

3. **WAGE OR SALARY AS OF DATE OF ACCIDENT:**
   $________**PER HOUR $**___________**PER WEEK $**___________**MONTHLY**

4. **NUMBER OF DAYS WORKED PER WEEK:**_______ **HOURS PER DAY**__________
   OVERTIME____________

5. **HAS EMPLOYEE FILED CLAIM FOR BENEFITS UNDER ANY WORKMEN'S COMPENSATION OR SIMILAR LAW AS A RESULT OF THIS ACCIDENT?**
   YES__________ **OR NO** ___________

6. **HAS EMPLOYEE RECEIVED, IS HE/SHE RECEIVING OR IS HE ENTITLED TO RECEIVE BENEFITS UNDER ANY WORKMEN'S COMPENSATION OR SIMILAR LAW AS A RESULT OF THIS ACCIDENT?**
   YES___________ **NO**____________ **UNDETERMINED**____________

7. **DATES ABSENT FOLLOWING ACCIDENT:**
   A. **Date Disability Began:** ____________________________
   B. **Date Returned to Work:** ____________________________

DATE:________________________________

SIGNED:_______________________________ **TITLE:** __________________________________

TELEPHONE:__________________________