WAGE AND SALARY VERIFICATION

DATE	OUR CLIENT	DATE OF ACCIDENT

EMPLOYEE'S NAME AND ADDRESS

SOCIAL SECURITY NO.

Gentlemen:
The above named person has sustained injuries in an automobile accident on the date indicated. We understand this person is your employee or former employee. Please answer the following seven questions, and return this form promptly.

1. DATES OF EMPLOYMENT: FROM: _____ THROUGH _____

2. DATES ABSENT FOLLOWING ACCIDENT: FROM:_____ THROUGH _____

3. WAS EMPLOYEE PAID DURING THIS ABSENCE? Yes ☐ No ☐ IF "YES", AMOUNT PAID $

4. IS EMPLOYEE ENTITLED TO BENEFITS UNDER A WAGE OR SALARY CONTINUATION PLAN? Yes ☐ No ☐

5. NAME OF YOUR WORKMEN'S COMPENSATION INSURER: _____

6. HAS OR WILL A CLAIM BE FILED UNDER ANY WORKMEN'S COMPENSATION LAW FOR THIS ACCIDENT? Yes ☐ No ☐

7. SCHEDULE OF WEEKLY EARNINGS – FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

WEEK			NO. OF DAYS WORKED	AMOUNT EARNED INCLUDING OVERTIME OR EXTRA WORK	GRATUITIES				GROSS EARNINGS
NO.	FROM DATE	TO DATE			MEALS	BOARD	TIPS	ALL OTHER	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									

TOTAL _____

EMPLOYER_____ DATE _____ SIGNED _____ TITLE _____