WAGE AND SALARY VERIFICATION

Name of Employee: _____

Date of Injury: _____

Employer's Name and Address: _____

_____

_____

Please provide the following information:

1. OCCUPATION OF INJURED: _____

2. DATES OF EMPLOYMENT: FROM: _____ THROUGH: _____

3. WAGES OR SALARY AS OF DATE OF INJURY: $_____
   ( ) PER WEEK
   ( ) PER MONTH
   ( ) PER YEAR

4. HOURLY WAGE, IF PAID BY THE HOUR: $_____

5. USUAL NUMBER OF DAYS WORKED PER WEEK: _____

6. USUAL NUMBER OF HOURS WORKED: Per Day _____
   Per Week _____

7. WAS INJURED EMPLOYEE ENTITLED TO OVERTIME PAY IF HE OR SHE WORKED OVERTIME? ( ) YES ( ) NO
   IF YES, AT WHAT RATE: _____

8. DATES ABSENT FROM WORK DUE TO INJURY:

   a. Date Disability Began: _____

   b. Date Returned to Work: _____

This the _____ day of _____, 2021.

_____
SIGNATURE OF EMPLOYER
TITLE: _____