**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