WAGE & SALARY VERIFICATION FORM

EMPLOYEE NAME: _____ POSITION: _____

SOCIAL SECURITY #: _____ DATE OF ACCIDENT: _____

The above employee missed the following dates and/or hours from his/her job after the above mentioned accident:

DATE	HOURS MISSED	DATE	HOURS MISSED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total Hrs Absent: _____ Wage/Hr: _____ Total Lost Wages:_____

_____ _____

Supervisor Name (print) Supervisor Signature

_____ _____

Title Telephone Number

_____

Date Completed

THIS CAN BE PREPARED ON YOUR COMPANY'S LETTERHEAD OR COMPLETED ABOVE. COPIES MAY BE MADE IF NECESSARY. THE COMPLETED DOCUMENT SHOULD BE MAILED OR FAXED TO:

RG LAW, PLLC
9990 Fairfax Blvd, Suite 540
FAIRFAX, VA 22030
Phone: (703) 352-8833/Fax: (703) 352-8881