

# EMPLOYERS WAGE AND SALARY VERIFICATION

NAME OF COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_

POSITION OR TITLE: \_\_\_\_\_

STARTING DATE: \_\_\_\_\_

WAGE/SALARY:  
(Hourly, Monthly, Year, etc.) \_\_\_\_\_

COMMISSION: (If applicable) \_\_\_\_\_

TOTAL HOURS/DAYS ABSENT: \_\_\_\_\_

TOTAL LOST WAGES TO DATE: \_\_\_\_\_

\_\_\_\_\_  
Authorized Representative of Company

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date