WAGE VERIFICATION FORM

EMPLOYEE NAME: ___________________________________

DATE OF ACCIDENT: _________________________________

1. How long has this employee been employed by your company?
____

2. What position did he/she hold as of the above accident date?
____

3. Did this person lose any time from work as a result of any injury received in this accident?
____
If so, dates missed: ____
If so, hours missed: ____

4. What was the employee's rate of pay at the time of the accident?
____

5. How many hours per week does this employee work? _________________________________

6. Has this person returned to work since the above accident date? ________________________
If so, on what date did he/she return? ____

7. Is this person still employed by you as of this date? __________________________________

8. What is this employee's rate of pay as of this date? ___________________________________

9. PLEASE COMPUTE THE TOTAL AMOUNT OF WAGES LOST BY THIS EMPLOYEE AS A RESULT OF THE ABOVE-REFERENCED ACCIDENT, INCLUDING ANY OVERTIME THAT THE EMPLOYEE WOULD BE ENTITLED TO.

TOTAL LOST WAGES: ________________________________

Name of Company: ___________________________________

Address: ____

____

OFFICIAL'S SIGNATURE/TITLE CERTIFYING THE ABOVE:

____

DATE SIGNED: ____

I HEREBY AUTHORIZE MY EMPLOYER TO RELEASE THE ABOVE INFORMATION TO MY ATTORNEY WITH **Stiles Law, LLC, 402 West Trade St., Suite 101, Charlotte, NC 28202**.

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EMPLOYEE SIGNATURE