Wage Loss Verification Form

This form is to be filled out by your employer.

TO THE EMPLOYER:

This statement is for the benefit of your employee in connection with the claim for damages resulting from an accident, which was in **no way** connected with our client's employment at your company. It would be beneficial to our client if this form is filled out completely.

Name of Employer:	
Your Name:	
Your Position/Title	
Address:	
Telephone #	
Employee Information	
Name of Employee:	
Address:	
Employee's Position:	
Employee's Duties:	
Salary of Employee	***Per hour: $*** ***Hours Per week:***
	*Bonus, commissions or overtime pay lost, **if any:***
Did Employee lose any earnings due to this accident?	☐ **YES** ☐ **NO** * *Hours lost multiplied by the wage of employee*
	Total Hours Lost From Work:
	Total amount lost from work: **$**
Comments?	

***** Any Person Who Knowingly Files A Statement Of Claim Containing Any False Or Misleading Information Is Subject To Criminal And Civil Penalties. *****

Signed by:	Today's Date:
Print Your Name:	Your Contact Telephone #:

Return to: ***Bonar Law Group*** - 1 Centerpointe Dr. Suite #100 | La Palma, CA 90623
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