EMPLOYER'S CONFIRMATION OF INCOME LOSS

Name of Employee: ____

Date of Accident: ____

1) Employees hourly wage; ____

2) Normal deductions from hourly wage ____

3) Numbers of hours normally worked per week; ____

4) Amount of overtime normally worked per week; ____

5) Annual Salary; ____

6) Date sick leave commenced (due to accident); ____

7) Date employee returned to work; ____

8) Date employee returned to work full time or part time; ____

9) If part time, how long before employee returned to work full time? ______________________________

10) Amount of salary lost due to accident related illness; ____

11) What medical benefits coverage is provided to employee? ______________________________________

12) Does employee contribute to this plan? ____

13) Are their currently any restrictions in the employees ability to do his job? ________________________

14) Amount of overtime paid to employee in the year prior to the accident ; ________________________

14) Amount of overtime missed during sick leave; ____

Signature of employer: ____

Position: ____

Date: ____

Telephone Number of Employer: ____