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Lost Wage Verification

Name of Employer: _____

Name of person filling out this Lost Wage Verification_____

Contact Address and Phone Number_____

I am employed by _____, and my position at the place of employment is_____, therefore I am qualified to attest that employee, _____, has lost a total of _____ hours and _____ benefits (as shown below). Said employee makes the sum of _____ and therefore has lost a total of $_____ as a result of having to take off of work for the injuries incurred.

_____
Signature of Employer

Date of Missed Work	Hours Missed of Work	Total Wages Lost