Verification of Lost Wages

Your employer must complete this form and return it directly to our office.

Employee Name: ____

Social Security No.: ____________________________ Date of Birth: ___________________________

Position Description: ____

Rate of Pay: $___________ per ___________

Date the employee was hired: ___________________

Date the employee was terminated from employment (if applicable): ______________________________

Reason for termination: ____

1. What date was the employee first unable to report to work? _________________________

2. What date did the employee return to work part-time (if applicable)? _________________________

3. What date did the employee return to work full-time (if applicable)? _________________________

4. Number of regular hours worked per week: _________________________

   Number of overtime hours per week (if applicable) _____________ Overtime hourly wage _________

5. The employee was off work: __________ REGULAR HOURS __________ OVERTIME HOURS

6. Did the employee receive compensation through work leave? Yes ☐ No ☐

   If yes, amount received: ____________________________

7. Was the employee eligible for company health insurance? Yes ☐ No ☐

   Name and Address of the insurance carrier: ____

8. If the injury was job-related, was the employee eligible for Worker's Compensation? Yes ☐ No ☐

SECTION MUST BE COMPLETED BY EMPLOYER

Employer: ____

Person completing form (print): _______________________________ Title: _____________________

Address: ____

Phone No. (______)____________________

Signature: ____ Date: ____________________

Comments? ____

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Please return form to

Violent Crimes Compensation Board
PO Box 110230
Juneau, AK 99811
Fax: 907.465.2379
Email: doa.vccb@alaska.gov