

## **EMPLOYMENT INFORMATION FORM**

This form is completed by the claimant's employer (at the time of the incident in their claim) and sent by the employer to the Board. If there is additional information that would be helpful to the VCCB in determining the amount of time a claimant missed from work and their related loss of wages, employers are encouraged to submit the information.

Forms completed by a claimant will not be used to support requests for crime victim compensation of lost wages. Persons who are self-employed must submit their income tax returns for the three years prior to the incident in their claim.

### Instructions for Completing the **EMPLOYMENT INFORMATION FORM**

#### NAME OF EMPLOYEE:

1. Employer prints or types the employee's full/legal name

#### SSN:

2. Employer prints or types the employee's social security number

#### POSITION:

3. Employer prints or types the title of their employee's position

#### RATE:

4. Employer enters the amount paid to the employee per hour or per week or per month and circles hour or week or month

#### NUMBER OF HOURS PER WEEK USUALLY WORKED:

5. Employer enters the number of hours per week that the employee usually worked at the time of the incident

#### DATE HIRED:

6. The date the employee was hired

#### DATE TERMINATED

7. If the employee has been terminated, the employer enters the date the employee was terminated

#### REASON FOR TERMINATION

8. If the employee has been terminated, the employer provides a brief description of the basis for the termination

#### EMPLOYEE LOST WORK DUE TO (INJURY/DEATH) WHICH OCCURRED:

9. Employer provides the date that the incident occurred for which the employee is claiming lost wages and circles injury or death

DATE EMPLOYEE RETURNED TO WORK

10. The date the employee returned to work  
Note: If the employee was not able to return to work full-time or work the same number of hours as before the incident, employer should enter the date on this form and provide a separate written explanation.

EMPLOYEE WAS OFF WORK

11. Employer enters the number of hours or days or weeks or months the employee was off work as a direct result of the incident in their claim

DID EMPLOYEE RECEIVE SICK LEAVE PAY FOR THE ABOVE TIME?

12. Employer enters yes or no

AMOUNT RECEIVED

13. Employer enters the total amount (dollar value) the employee received for the hours or days or week or months that the employee was compensated for the time missed as a direct result of the incident in the claim.
14. Employer enters hours or days or weeks or months- whichever is appropriate

IF EMPLOYEE WAS ELIGIBLE FOR COMPANY INSURANCE, PLEASE STATE THE NAME AND ADDRESS OF THE CARRIER

15. If pertinent, employer enters the information

WAS EMPLOYEE ELIGIBLE FOR WORKMENS' COMPENSATION BENEFITS?

16. Employer enters yes or no

IF NOT, STATE REASON

17. If injury/death was not work related, employer must complete this blank

Employer must complete all information asked for at the bottom of the form and sign and date the form. The employer sends the form directly to PO Box 110230, Juneau, AK. 99811-0230.

Please call 1-800-764-3040, if there are any questions.