WAGE VERIFICATION FORM

NAME OF EMPLOYEE: _____
DATE OF ACCIDENT: _____

1. How long has this employee been employed by your company? _____

2. What position did he/she hold as of the above accident date? _____

3. Did this person lose any time from work as a result of any injury received in this accident? _____
   If so, dates missed: _____
   If so, hours missed: _____

4. What is this employee's rate of pay? _____

5. How many hours per week does this employee work? _____

6. Has this person returned to work since the above accident date? _____
   If so, on what date did he/she return? _____

7. Is this person still employed by you as of this date? _____

8. What was the employee's rate of pay at the time of the accident? _____

9. PLEASE COMPUTE THE TOTAL AMOUNT OF WAGES LOST BY THIS EMPLOYEE AS A RESULT OF THE ABOVE-REFERENCED AUTOMOBILE ACCIDENT, INCLUDING ANY OVERTIME THAT THE EMPLOYEE WOULD BE ENTITLED TO:
   TOTAL LOST WAGES: $_____

Name of Company: _____
Address: _____
_____

This information is current through: _____

OFFICIAL'S SIGNATURE AND TITLE CERTIFYING THE ABOVE:

_____

I HEREBY AUTHORIZE MY EMPLOYER TO RELEASE THE ABOVE INFORMATION TO MY ATTORNEYS, BROWN, BROWN & BROWN, P.L.L.C., POST OFFICE BOX 400, ALBEMARLE, NORTH CAROLINA 28002.

_____
Employee's Signature