Instructions

If you missed time from work because of injuries sustained in the accident and you intend to file a claim for medical or wage loss expenses, you must have your employer complete the Wage and Salary Verification form.

You will need to fill out the current date, your name, the date of the accident and your claim number (if known), and give the form to your employer. Your employer will need to complete the form and **if possible** attach a business card or company stamp. Then please return it to OEB Law, PLLC. (*Form Below)*

WAGE AND SALARY VERIFICATION

DATE	COMPANY	DATE OF ACCIDENT	CLAIM NUMBER IF KNOWN

____
Employee's Name

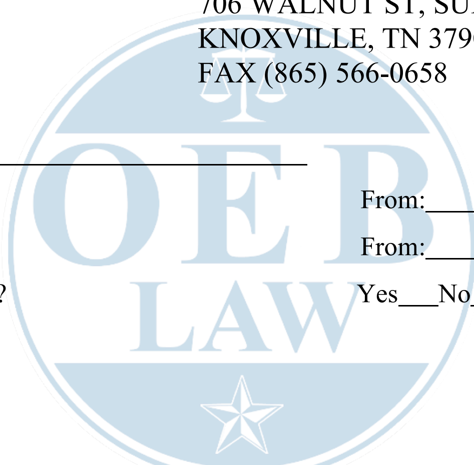
____

____
Employee's Address

Dear Sir or Madam:

The above named person sustained injuries as a result of an automobile accident on the date indicated. We understand this person is your employee or former employee. To determine what monies may be due to the injured party, please provide us with responses to the following questions, and return this form promptly. Thank you for your cooperation.

OEB LAW, PLLC
706 WALNUT ST, SUITE 700
KNOXVILLE, TN 37902
FAX (865) 566-0658



1. Occupation: ______________________________
2. Date of Employment: From:____________Through: ____________
3. Dates absent following accident: From:____________Through: ____________
4. Was employee paid during this absence? Yes___No___If Yes, Amount Paid $__________

5. SCHEDULE OF WEEKLY EARNINGS FOR **13 WEEKS PRIOR TO DATE OF ACCIDENT**

WEEK NO.	**WEEK**		**NO. OF DAYS WORKED**	**AMOUNT EARNED INCLUDING OVERTIME OR EXTRA WORK**	**ADDITIONAL COMPENSATION**				**GROSS EARNINGS**
	FROM DATE	**TO DATE**			**MEALS**	**BOARD**	**TIPS**	**ALL OTHER**	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
TOTAL									

For your protection, Tennessee law requires the following to appear on this form:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

EMPLOYER:__________________DATE:________PHONE #:______________TITLE: ____________

SIGNED:________________________________ PRINT NAME______________________________