

PITTENGER LAW OFFICE, PLLC

WAGE AND SALARY VERIFICATION

Date	Our Policy Holder	Accident Date	File Name
Employee's Name and Address:			
TO WHOM IT MAY CONCERN: The above-named person has applied for benefits under the Kentucky No-Fault Law as a result of injuries sustained in an automobile accident on the date indicated above. We understand this person is your employee, or former employee. To assist us in determining benefits that may be due this person, please provide us with the answers to the following questions:			
1. Occupation		2. Dates of Employment	
3. Wage or Salary (Gross) as of Date of Accident: \$ _____ per hour \$ _____ per week \$ _____ per month		4. Average Number of Hours Worked per Week: Average Overtime Hours:	
5. Dates Absent Due to This Accident:		6. If not Consecutive, Dates Absent or Total Number of Days:	
7. Has Employee Filed Claim for Benefits Under any Workers' Compensation or Similar Law as a Compensation Act or Similar State or Federal Law as a Result of This Accident? Yes ___ No ___ If Yes, Name of Insurer: _____			
8. Has Employee Received, is he Receiving, or is he Entitled to Receive Benefits Under any Workers' Compensation Act or Similar State or Federal Law as a Result of This Accident? Yes ___ No ___ Undetermined ___ If "Yes", Name of Insurer: _____			
Social Security Number:		Date of Return to Work:	
		Partial Status ___ Full Status ___	

Signature: _____ Title: _____

Print name: _____

Name of Company: _____ Address: _____

Date: _____ Phone number: _____