WAGE AND SALARY VERIFICATION TO BE COMPLETED BY EMPLOYER

Employee:_____

Employer:_____

Date/Accident:_____

SS#:_____

Payroll Department:

This law firm represents the above employee. It is necessary for us to obtain the information requested below regarding our client. Please complete this form and return it to Brett M. Bressler, P.A., 2707 W. Fairbanks Ave. Ste. 100, Winter Park, FL, 32789, (407) 599-2002, fax: (407) 599-2007. Thank you.

_____

Employee

1. DATES OF EMPLOYMENT: FROM:_____ THROUGH:_____

2. DATES ABSENT FOLLOWING ACCIDENT: FROM:_____ THROUGH:_____

3. WAS EMPLOYEE PAID DURING THIS ABSENCE? YES ☐ NO ☐ IF "YES", AMOUNT PAID $_____

4. IS EMPLOYEE ENTITLED TO BENEFITS UNDER A WAGE OR SALARY CONTINUATION PLAN? YES ☐ NO ☐

5. NAME OF YOUR WORKMEN'S COMPENSATION INSURER.. _____

6. HAS OR WILL A CLAIM BE FILED UNDER ANY WORKMEN'S COMPENSATION LAW FOR THIS ACCIDENT? YES ☐ NO ☐

7. SCHEDULE OF WEEKLY EARNINGS — FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

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

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

Pursuant to Florida Statute 627.736 (6) "Under penalty of perjury I declare that I have read the foregoing and the information provided above is true to the best of my knowledge and belief."

EMPLOYER _____ DATE _____ SIGNED _____ TITLE _____