



# State of Nevada Victims of Crime Program

## Employers Verification of Employment and Lost Wages

*Use this form to verify applicant/employee's wage loss information when applicant is requesting lost wage reimbursement.*

### Employee Information:

Employee Name:	Last 4 digits SSN:	VOCP Claim #
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### Employer Information:

Employers Name:	Phone:	Fax:
Employers Mailing Address:	City, State, Zip:	

### Employee Lost Time Information:

Did employee miss work due to his or her <i>crime injuries</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If <i>Yes</i> : Enter first date not worked:	If employee missed work did they return? <input type="checkbox"/> Yes <input type="checkbox"/> No If <i>Yes</i> : Enter date returned to work:	If employee did not return to work please indicate why: <input type="checkbox"/> Employee is still off work due to the crime injuries. <input type="checkbox"/> Employee no longer employed with this employer
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### Employee Hours and Wage Loss Information:

Number of Hours Worked: <input type="checkbox"/> _____ Per Day <input type="checkbox"/> _____ Per Week <input type="checkbox"/> _____ Per Pay Period <input type="checkbox"/> _____ Other:	Amount Paid: \$ _____ <input type="checkbox"/> _____ Hourly <input type="checkbox"/> _____ Daily <input type="checkbox"/> _____ Weekly <input type="checkbox"/> _____ Other:	Total amount of wages lost by employee due to crime injuries: \$ _____
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Did employee receive other compensation in addition to wages stated above (tips, commissions, bonuses, etc)?

Yes If *Yes*, please state average daily additional compensation: \$ \_\_\_\_\_

No

### Employee Insurance Information:

At the time of the crime, did the employee have medical insurance coverage through the employer or a union?

Yes If *Yes*, Name of insurance carrier & policy number or name and address of union:

No

If Employee is deceased, were life insurance benefits paid to beneficiaries?

Yes If *Yes*. Names of beneficiaries and amounts paid:

No

***I certify that the information provided is true and correct to the best of my information and belief.***

Authorized Signature:	Print Name:	Title:
Date:	Telephone:	Email:

<i>Mail to:</i> VOCP P O Box 94525 Las Vegas, NV 89193-1525	<i>Fax to:</i> (702) 458-5586	<i>Scan and email to:</i> applications@voc-net.com
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