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 #

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 *crime injuries*?	If employee missed work did they return?	If employee did not return to work please indicate why:
○ Yes ○ No If *Yes*: Enter first date not worked:	○ Yes ○ No If *Yes*: Enter date returned to work:	○ Employee is still off work due to the crime injuries. ○ Employee no longer employed with this employer

Employee Hours and Wage Loss Information:

Number of Hours Worked:	Amount Paid: $ _____	Total amount of wages lost by employee due to crime injuries:
○ _____ Per Day ○ _____ Per Week ○ _____ Per Pay Period ○ _____ Other:	○ _____ Hourly ○ _____ Daily ○ _____ Weekly ○ _____ Other:	$ _____

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:

Mail to: VOCP P O Box 94525 Las Vegas, NV 89193-4525	*Fax to:* *(888) 941-7890*	*Scan and email to:* *applications@voc-net.com*