



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

Number of Hours Worked: ☐ _____ Per Day ☐ _____ Per Week ☐ _____ Per Pay Period ☐ _____ Other:	Amount Paid: \$ _____ ☐ _____ Hourly ☐ _____ Daily ☐ _____ Weekly ☐ _____ 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
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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 500 E. Warm Springs Rd. #100 Las Vegas, NV 89119	Fax to: (702) 486-2825	Scan and email to: vocp@dcfs.nv.gov
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*30 days' worth of proof of income required