Authorization to Release Lost Wage Information

I authorize my employer to release any and all information pertaining to my loss of wages due to the accident I was involved in on________________________.

____
Client Signature

____

Lost Wage Statement

Employer Name: ____

Address: ____

Your Name: ____

Your Position with Employer: ____

Employee's Name: ____

Employee's Social Security Number: ____

Employee's Address: ____

____

Position ofEmployee: ______________________________________

Earnings (Complete applicable one)

Hourly: $ __________ Weekly: $ ___________

Annual Salary: $ _____________ Other: $ __________ per ____________

*If employee is paid commission only or base plus commission, simply take the employee' s *average* pay for whatever pay period your company uses.

Earnings Loss Due to Accident

Accident Date: ________________

List Work Days/Hours Missed Resulting From Accident:

Example: 2/1/99 8 hoursor if consecutive days
2/1/99 - 2/5/9940 hours

Date(s):__________________________ Hours: __________________

__________________________ __________________

__________________________ __________________

__________________________ __________________

__________________________ __________________

__________________________ __________________

__________________________ __________________

Total Hours Missed: __________________

Comments: ____

____

The above information is true to the best of my knowledge:

(employer signature)_______________________________________

____
(print the name of above)

Please return this form in the envelope provided to:

Kevin F. Kurgis, Attorney at Law
100 South 4th Street, Suite 300
Columbus, Ohio 43215
Fax: 614-464-1616 Phone: 614-464-1610