



## WAGE LOSS FORM

DATE: \_\_\_\_\_

TO: CLAIMS DEPARTMENT

RE: \_\_\_\_\_

**CLAIM NUMBER:** \_\_\_\_\_

The above worker attended a hearing with the Appeals Commission on \_\_\_\_\_.

To allow us to promptly reimburse the worker for wage loss in attending the hearing, please answer the following questions and forward the form to the CLAIMS DEPARTMENT.

- |   | YES      | NO       |
|---|----------|----------|
| 1. Will the worker be paid full salary for the time missed to attend the meeting with the Appeals Commission? |          |          |
| 2. Number of hours missed:  | _____    | hours    |
| 3. Rate of pay:   | \$ _____ | per hour |
| 4. Normal work day:   | _____    | hours    |
| 5. Normal work week:  | _____    | hours    |
| 6. Average daily gross wage:  | \$ _____ |          |

EMPLOYER'S SIGNATURE \_\_\_\_\_

POSITION \_\_\_\_\_

DATE \_\_\_\_\_