saifcorporation

Claim For Lost Earnings While Attending Required Medical Exam

Name of worker _____ Claim no. _____

Date of examination _____

Name of doctor or hospital _____

Date and time left work _____

Date and time returned to work _____

Working hours lost _____

Hourly wage _____

Net lost wages (after taxes and other deductions) _____

I certify the above information is correct.

_____

Signature Date

Employer's Verification

I certify that the above worker was absent from work for the period indicated and that the worker's net lost wages (after deductions) were $ _____.

_____

Employer signature Date

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