VICTIM COMPENSATION WAGE LOSS EMPLOYMENT REPORT

INSTRUCTIONS TO VICTIM: PLEASE DO NOT WRITE ON THIS FORM. Wage loss compensation is offered to eligible victims who missed time from work due to the severity of their crime injuries. Wage loss benefits are also available to the victim's legal guardian, when he or she missed time from work to provide immediate medical care to the minor victim. Lost wages are compensable within the timeframes established and up to the percentage and maximum benefit amount on the Schedule of Benefits, based on the victim/applicant's gross average weekly wage. You may forward this form to your employer to document your loss of earnings. Self employed individuals should instead submit their most recent federal income tax return with W2 or Schedule C attachments.

INSTRUCTIONS TO EMPLOYER: This form must be completed by the human resources director or other authorized human resources supervisor, employee administrative services supervisor, chief financial officer, chief executive officer, president, or owner. Please consider completing this form to qualify your employee for wage loss benefits. Please send this form to the Office of the Attorney General, Bureau of Victim Compensation, PL-01, The Capitol, Tallahassee, FL 32399-1050, or by facsimile to (850) 414-6197 or (850) 414-5779, or email to VCIntake@MyFloridaLegal.com. Please provide a copy of this information to your employee.

SECTION ONE: VICTIM/APPLICANT INFORMATION (please print)

1. Victim/Applicant's Name (last, first, middle): ____________________
2. Date of Birth: _____/_____/_____ 3. Last Four Social Security Number: XXX-XX-_______

SECTION TWO: EMPLOYMENT/BENEFITS INFORMATION (please print)

1. Victim/Applicant's Job Title: ____________________
2. What is the average number of hours the victim/applicant worked per week? ____________________ (hours)
3. Date Hired: ______________ 4. Date Terminated, if applicable: ______________
5. Please check any benefits that the employee was eligible for at the time of the crime.

☐ Workers' Compensation ☐ Short/Long-Term Disability Benefits ☐ Group Medical/Dental Insurance

☐ Other (please specify): ____________________

6. Please specify the time missed from work as a result of the crime injuries.

Start Date: ______________ End Date: ______________

7. What was the total number of hours missed from work as a result of the crime? ______________ (hours)

SECTION THREE: SALARY INFORMATION (please print)

1. If paid an hourly rate, enter the hourly wage. (Please include tips, commissions, mandatory overtime, etc.) $______________
2. If wage varies by week, show the average weekly wage amount. $______________

SECTION FOUR: EMPLOYER'S INFORMATION (please print)

1. Business/Company Name: ____________________
2. Mailing Address: ____________________ 3. City: ______________ 4. State: _____ 5. Zip Code: _______
6. Telephone Number: ______________ 7. Facsimile Number: ______________ 8. Email Address: ______________
9. Name of Immediate Supervisor: ______________ 10. Supervisor's Telephone Number (if different): ______________
11. Name of Business Representative Completing Form: ______________ 12. Title of Representative: ______________

BY SIGNING THIS FORM, I AFFIRM THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

13. Signature of Business Representative: ____________________ 14. Date Signed: ______________

The Office of the Attorney General, Bureau of Victim Compensation is an equal opportunity provider and employer.