

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 payable up to 66.667 percent based on the actual gross average weekly wage, the maximum benefit, or the maximum established by the Department of Financial Services. 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: _____

Victim:
BVC Analyst:

Claim Number:
Crime Date: