Whiteman, Hamilton & Conklin, LLC
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LOST WAGE FORM

Employee:_____
Social Security Number:_____ Date of Birth:_____
Employer:_____

The above individual has retained this firm to represent him/her in a claim for personal injuries. A part of this claim is any time he/she may have lost from work. This may take the form of sick leave and leave with or without pay. Please provide the requested information.

1. How long with the company? From: _____

   To: _____

2. Job title or description: _____

3. Wage/Salary as of the date of accident: _____

per___ hour ___ day ___ week ___ month

Hours in normal week: _____

4. Dates absent following accident: From: _____

   To: _____

5. Total amount of wages lost: $ _____

Date: _____ Signed: _____

Title: _____

Employer: _____

Address: _____

_____