EMPLOYER'S WAGE VERIFICATION FORM
(Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: _____ Injured Employee's Name (Last/First/M.I.): _____ Social Security # _____

Claim No.: _____ Date of Injury: _____ Date of Hire: _____

Was employee hired to work 40 hours per week: [ ] Yes [ ] No If no, # of hours per week: _____ # of days per week: _____

On the date of injury, the employee's wage was: $ _____ per [ ] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: _____

Was vacation paid during the applicable twelve week period?_____ If so, during what pay period? _____

Was sick leave paid during the applicable twelve week period? _____ Was the injured employee paid for any holidays during the applicable twelve week period? _____ Did employee receive payment for overtime during the applicable twelve week period? _____ Did employee receive termination pay during the applicable twelve week period? _____

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ _____ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: _____ Explain: _____

Does the employee receive commissions? [ ] Yes [ ] No Period of commission earned _____ to _____.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ _____

Does the employee receive bonuses/incentive pay? [ ] Yes [ ] No Period of bonuses/incentive pay earned _____ to _____.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ _____

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [ ] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [ ] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [ ] No **(Do not include in gross earnings)**

How many meals per day?_____ Monetary value of meals $_____per [ ] Day [ ] Week [ ] Month

Lodging $_____per [ ] Day [ ] Week [ ] Month

TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from _____ through _____. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.
1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

Payroll Period Beginning / Ending	Gross Salary (Excluding Tips)	Declared Tips	Payroll Period Beginning / Ending	Gross Salary (Excluding Tips)	Declared Tips

Dates of Absence Begin / End	Reason	Dates of Absence Begin / End	Reason	Dates of Absence Begin / End	Reason

Pay period ends on (check one) [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday
Employee is paid: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other
Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other
Explain "other":
Date the employee last worked AFTER injury occurred: _____ Date returned to work: _____

This information is true and correct as taken from the employee's payroll records.

Print Name: _____ Signature: _____

Date: _____ Employer: _____

Insurer: _____ Third-Party Administrator: _____ D-8 (rev10/10)