FIRM LETTERHEAD

WAGE AND BONUS LOSS FORM

DATE ________________

TO THE EMPLOYER:

This wage and bonus loss form is for the benefit of your employee in his or her claim arising out of an instance of medical malpractice that in no way arose in connection with his or her employment with your company. It will be to your employee's advantage if this form is filled out completely.

Employer name: ______________________

Company address: ______________________
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Name of employee: ______________________

Social security no. : ______________________

Telephone: ______________________

Date employed: ______________________

Time lost from work : from _______________ to ______________

Salary: $ ____________ per ____________

Hours worked per week: ____________________________________

Bonus, commission or overtime lost, if any : $________________
Employee’s regular duties:

Comments:

Signed ___________________________
Official title ____________________
Telephone _______________________

I hereby authorize my employers to release the requested wage and bonus information to my attorneys:

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Employee signature: ____________________________________

Date: ____________________________________