

Utah Office for Victims of Crime
350 East 500 South, Suite 200
Salt Lake City, UT 84111
Phone (801)-238-2360, Toll Free (800)621-7444
Email crimevictims@utah.gov

CLAIM FOR CRIME RELATED LOSS OF WAGES

Must be completed by Employer

Claimant's Name: _____ Victim's Name: _____ Claim: _____

If you are claiming loss of wages, this form MUST be completed by your employer and received in our office before benefits can be determined.

Este formulario DEBE ser completado por su empleador y recibido en nuestra oficina antes de que se puedan determinar los beneficios.

If self-employed, submit this form and a copy of your federal income tax return for years specified by your Reparation Officer.

Employer please provide the following:

1. Employee's name: _____ Job Title: _____
2. Dates employed: From: _____ To: _____
3. Rate of pay (include and tips, commission, etc): \$ _____
4. Days worked per week: _____ Hours scheduled per shift: _____
5. Date of incident/injury: _____ Was employee employed on the date of incident/injury? _____
6. Has the employee returned to work?
 - a. If yes, date returned: _____
 - b. If no, please explain: _____
7. Does employee have medical insurance through employer? _____
 - a. If yes, name of insurance carrier: _____
8. Does employee have disability insurance? _____
 - a. If yes, what days were covered? _____
9. Please list dates and times employee missed work related to this injury: _____

10. Employer Address: _____
11. Employer Phone: _____ Email: _____
12. Name of Employer Representative: _____ Job Title: _____
13. Employer Representative Email: _____ Phone: _____

Employer Representative Signature

Date

Please submit completed form to the address listed above. If there are any questions or concerns, please contact our office.