VICTIM COMPENSATION PROGRAM
Eighteenth Judicial District
6450 S. Revere Pkwy.
Centennial, CO 80111
Phone: (720) 874-8787
Fax: (720)733-4697
Email: VictimComp@da18.state.co.us

CASE #_____

LOST WAGE FORM

THE PROGRAM WILL ONLY COMPENSATE THE VICTIM FOR WAGES LOST DUE TO PHYSICAL OR EMOTIONAL INJURIES DIRECTLY CAUSED BY THE CRIME.

IF YOU ARE REQUESTING LOST WAGES, TAKE THIS FORM TO YOUR EMPLOYER AND HAVE IT COMPLETED AND SIGNED BY YOUR SUPERVISOR/EMPLOYER. IF YOU ARE SELF-EMPLOYED YOU MUST SUBMIT COPIES OF YOUR TAX RETURNS. IF CLAIMING LOST WAGES, YOU MUST SUPPLY THE FOLLOWING DOCUMENTATION:

1) **THIS FORM MUST BE COMPLETED AND RETURNED BEFORE YOUR REQUEST FOR LOST WAGES CAN BE PROCESSED. PLEASE RETURN THE ORIGINAL FORM WITH YOUR APPLICATION OR SEND TO THE ADDRESS LISTED ABOVE.**
2) **IF YOU ARE REQUESTING LOST WAGES FOR MORE THAN 1 WEEK, A LETTER IS REQUIRED FROM YOUR TREATING PHYSICIAN OR THERAPIST INDICATING YOUR INABILITY TO WORK DUE TO INJURIES SUSTAINED AS A RESULT OF THE CRIME. THE LETTER MUST INCLUDE THE RELEASE DATE FOR RETURNING TO WORK.**

EMPLOYEE'S NAME:		EMPLOYEE'S PHONE NUMBER:
DATE OF BIRTH: / /	JOB TITLE:	SOCIAL SECURITY NUMBER
WAS THIS PERSON EMPLOYED ON THE DATE OF INJURY? ☐ YES ☐ NO	HAS THIS PERSON RETURNED TO WORK? ☐ YES ☐ NO RETURN DATE : / /	DATES MISSED:
WAS THIS PERSON INJURED WHILE AT WORK? ☐ YES ☐ NO	IF YES, WAS WORKERS COMP PAID ☐ YES ☐ NO	IF YES, THROUGH WHAT PERIOD FROM: TO:
WAS SICK LEAVE / ANNUAL LEAVE OR DISABILITY PAID? ☐ YES ☐ NO	IF YES, THROUGH WHAT PERIOD FROM: TO:	HOURS WORKED PER DAY
HOURS WORKED PER WEEK	HOURS WORKED PER MONTH	REASON FOR MISSED WORK
RATE OF PAY ☐ HOURLY ☐ WEEKLY ☐ COMMISSION $_____ ☐ MONTHLY ☐ DAILY ☐ OTHER _____		

TOTAL AMOUNT OF LOST WAGES: $ _____

BUSINESS NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

EMPLOYER OR SUPERVISOR'S NAME: _____

JOB TITLE: _____

PHONE NUMBER: _____

EMPLOYER OR SUPERVISOR'S SIGNATURE: _____