



Crime Victim Compensation Board

Twenty-Third Judicial District of Colorado

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PROUDLY SERVING DOUGLAS, LINCOLN AND ELBERT COUNTIES

Lost Wage and Employment Verification Form

Crime Victim Compensation (CVC) may consider lost wages due to physical or emotional injuries immediately following a compensable crime or for attendance of critical stage court hearings.

CVC does not consider lost wages already paid by personal/vacation, sick, or other paid time off.

CVC does not consider lost wages for the purpose of attending medical or mental health appointments.

If you are paid in cash, are self-employed, or are a contracted employee, you are required to attach a copy of your prior-year federal income tax return (i.e. IRS Form 1040 or Form 1099).

The following items are required to complete your lost wage request.

YOUR LOST WAGE REQUEST WILL NOT BE REVIEWED UNTIL ALL ITEMS ARE RECEIVED

1. Employer completed Lost Wage and Employment Verification Form
2. Paystubs for the period immediately prior to the compensable crime and the period(s) during your absence as noted on this form.
3. For requests of more than one (1) week, you **must** submit a letter of explanation (LOE) from a treating medical or mental health provider documenting your inability to work is due to injuries sustained as a result of the crime. The LOE must include the date you have been cleared to return to work.

THE FOLLOWING MUST BE COMPLETED BY YOUR DIRECT SUPERVISOR

EMPLOYER INFORMATION

Business/Company Name: _____

Mailing Address: _____

Telephone Number: _____

Name of individual completing form: _____

Job title of individual completing form: _____

Direct phone number: _____

Email: _____

EMPLOYEE INFORMATION

Victim (Employee) Name: _____

Victim (Employee) Job Title: _____

Date of Crime: _____

Was this person employed on the above date of crime? YES NO

Has this person returned to work? YES NO

If yes, date employee returned to work: _____

REQUIRED: In the space provided below, please note all dates the employee missed work due to the crime:

Average number of hours employee works per day: _____ per week: _____

Rate of pay: \$ _____ HOURLY WEEKLY MONTHLY OTHER

Total amount of wages being requested: \$ _____

Did the crime occur at work? YES NO

If yes, did the victim (employee) apply for Worker's Compensation? YES NO

If no, why not? _____

Were the employee's wages fully or partially covered by any of the following?

Type of Leave	Yes	No	Total # Hours Paid	Total # Weeks Paid
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>		
Long Term Disability	<input type="checkbox"/>	<input type="checkbox"/>		
Paid Time Off (personal/sick)	<input type="checkbox"/>	<input type="checkbox"/>		

By signing this form, you affirm the information provided above is true and correct to the best of your knowledge. Providing false information will result in the denial of your claim and possible legal action.

Victim (Employee) Signature Date

Supervisor/HR Rep Signature Date