



# Employer's Statement of Earnings

Case #:  
Date Sent  
Due Date

Employee's Name:  
Business Name:

SSN:

**Form may continue on to next page**

Employee Permission: I give my employer permission to share information about my employment. I will not take legal action against them for sharing this information. This permission will stop the last day of the twelfth month after the month I signed below.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MUST BE COMPLETED BY EMPLOYER**  
**EMPLOYER - Please complete sections below to verify employment information**

**NEW EMPLOYMENT**

Start date of employment \_\_\_\_/\_\_\_\_/\_\_\_\_ Date first check received \_\_\_\_/\_\_\_\_/\_\_\_\_

Please provide your best estimate of ongoing wages				
Type of Pay	Projected hours/week		Rate of Pay/Hour	
Regular				
Overtime				
Weekend/Shift Differential				
Pay Frequency (circle)	Weekly	Bi-Weekly	Semi-Monthly	Monthly
Tips, if received	\$	per week		
Salary, if not paid hourly	\$	per		

**Incentive/Bonus/Commission Pay**

Bonus Is this bonus one time or recurring? (Circle one)	\$ _____ per <b>Month/Quarterly/Annually</b> (circle one)  <b>What month is bonus received?</b> _____ If recurring, do you anticipate this bonus to be received regularly in the future? Yes or No If yes, how often?
Commission	\$ _____ per Is commission income recurring? Yes or No If recurring, do you expect commission to be received regularly in the future? Yes or No If yes, how often?
Other	\$ _____ per

Actual pay and best estimate of pay from _____ to _____				
Pay Period End Date (XX/XX/XXXX)	Date Pay Received (XX/XX/XXXX)	Hours Worked	Gross Pay (Before Deductions)	Is this check a good indication of future earnings?
				Yes or No
				Yes or No
				Yes or No
				Yes or No
				Yes or No
				Yes or No
				Yes or No
				Yes or No

If you answered No to a check not being a good indication of future earnings, please explain why it is not:  
  
 Are tips included in the gross pay? Yes or No or NA  
 Is Health Insurance available (circle one) Yes or No



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## ENDING EMPLOYMENT

Last date of employment \_\_\_\_/\_\_\_\_/\_\_\_\_ Date final check received \_\_\_\_/\_\_\_\_/\_\_\_\_

Gross pay of final check \$ \_\_\_\_\_

Does the final check include pay out of paid time off or vacation? Yes or No

If yes, list the amount of paid time off or vacation received on the final check \$ \_\_\_\_\_

Circle the reason job ended: Quit Fired Other \_\_\_\_\_

Was the employee working 30 hours a week or more? Yes or No

## LEAVE

### Please provide information on leave:

Date leave began \_\_\_\_/\_\_\_\_/\_\_\_\_

Circle pay status: Paid leave or Unpaid leave

If unpaid leave, when was their last check received? \_\_\_\_/\_\_\_\_/\_\_\_\_

What was the gross pay of this check? \$ \_\_\_\_\_

If paid leave, what type? (ie. Workmans comp, short term disability, etc.) \_\_\_\_\_

Date expected to return to work \_\_\_\_/\_\_\_\_/\_\_\_\_

### Work schedule/normal days scheduled per week (CCA)

Does schedule vary? (circle one) Yes No Other (explain) \_\_\_\_\_

If a varied schedule: Normal number of days scheduled to work per week (best estimate) \_\_\_\_\_

Average Number of hours worked per shift (best estimate) \_\_\_\_\_

Earliest possible shift start time \_\_\_\_\_ Latest possible shift end time \_\_\_\_\_

If a set schedule: Normal scheduled work hours (example 8 AM - 5 PM, please note if AM or PM):

\_\_\_\_\_  
 Sun Mon Tue Wed Thu Fri Sat

## Pretax Deductions

Please list the amount of pretax deductions taken from gross pay for:

Health insurance premiums \$ \_\_\_\_\_ per \_\_\_\_\_ (week/biweekly/semi-monthly/monthly)

Dental insurance premiums \$ \_\_\_\_\_ per \_\_\_\_\_ (week/biweekly/semi-monthly/monthly)

Retirement plan \$ \_\_\_\_\_ per \_\_\_\_\_ (week/biweekly/semi-monthly/monthly)

Health savings account \$ \_\_\_\_\_ per \_\_\_\_\_ (week/biweekly/semi-monthly/monthly)

Flex spending account \$ \_\_\_\_\_ per \_\_\_\_\_ (week/biweekly/semi-monthly/monthly)

Other \_\_\_\_\_ per \_\_\_\_\_ (week/biweekly/semi-monthly/monthly)

## Employer Information

Name of Person Completing the Form (please print)	Fax Number	Phone
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Signature of Person Completing the Form	Date
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Comments:

### Questions??? Please contact:

Worker Name	Worker Number	Phone Number	Fax Number	Toll Free Number
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Mailing Address	E-mail Address
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