GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 17 - REQUEST FOR VERIFICATION OF EMPLOYMENT

INSTRUCTIONS: This form is to be completed by the Employer for the Claimant named below. Please complete either part II or III as applicable. Complete part IV and return directly by e-mail to wcsecure@dc.gov.

Part I – Claimant Information

1. Claimant Name and Address:	2. Claim Number:
3. Claims Examiner:	4. Claims Examiner Phone Number:

Part II – Verification of Present Employment

5. Claimant's Hire Date:	6. Position(s) held: 6a. Permanent or Temporary Employee?	
7. Active or Inactive status?	7a. If inactive, date Claimant went on leave and date Claimant will be returning from leave:	
8. Current Gross Pay (Enter amount and check period) Annual / Hourly / Monthly / Weekly / Bi-weekly / Semi-monthly / Other (Specify: _____) $ _____	9. If overtime or bonus is applicable, are they routinely earned? Overtime: Yes/No Bonus: Yes/No	10. If paid hourly – average hours per week:

11. Gross Earnings

Type	Year to Date	Past Year	Past Year
Base Pay	$	$	$
Overtime	$	$	$
Commissions	$	$	$
Bonus	$	$	$
Total	$	$	$

Remarks (If employee was off work for any length of time, please indicate time period and reason)

Part III – Verification of Previous Employment *(Complete this section, if Claimant is no longer an employee).*

12. Date Hired	14. Salary/Wage at Termination Per (Year) (Month) (Week): $ _____ Base Overtime Commissions Bonus
13. Date Terminated	15. Position(s) Held
16. Reason for Leaving	

Part IV – Authorized Signature

17. Signature of Employer	18. Title (Please print or type)	19. Date
20. Print or type name signed on item 17	22. Phone Number	24. Email