

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM

CRIMINAL JUSTICE COORDINATING COUNCIL

104 MARIETTA STREET, SUITE 440 ★ ATLANTA, GEORGIA 30303-2743
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EMPLOYMENT VERIFICATION FORM

An application for Economic Support benefits was submitted to the Georgia Crime Victims Compensation Program (CVCP) for consideration. To help the CVCP make the best possible decision in determining eligibility, we would appreciate your assistance by providing the below information.

Employee/Victim

Address:

SSN:

Claim Number:

Date of Victimization:	
1. Dates of employment:	From: ____/____/____ To: ____/____/____
2. Hourly Wage: \$ _____ Employment type: Full-time <input type="checkbox"/> Part-time <input type="checkbox"/>	Annual Salary: \$ _____ Number of hours worked per week _____
3. Work dates missed due to victimization, OR employee/victim did not miss any days from work:	From: ____/____/____ To: ____/____/____ Check here if no work days missed <input type="checkbox"/>
4. Total amount of wages lost due to victimization.	\$ _____
5. Dates of paid leave: None <input type="checkbox"/> Annual <input type="checkbox"/> Sick <input type="checkbox"/> Sick & Annual <input type="checkbox"/> <input type="checkbox"/> Other: _____	From: ____/____/____ To: ____/____/____
6. Disability pay:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, what type: Short-Term <input type="checkbox"/> Long-Term <input type="checkbox"/> Worker's Compensation <input type="checkbox"/>	
Amount:	\$ _____
Dates of disability pay:	From: ____/____/____ To: ____/____/____

Company Name (print name)

Employer (print name)

Employer Signature

Date: ____/____/____

Telephone No.: ____ - ____ - ____

PLEASE NOTE:

TO BE VALID, This form must be attached to a blank copy of the employer's business letterhead or business card that includes the business contact information AND the documents must be faxed or mailed by the EMPLOYER.

