GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
104 Marietta Street, NW • Suite 440 • Atlanta, GA • 30303-2743
404/657-2222 • 800/547-0060 • 404/463-7652 (Fax) • 404/463-7650 (TTY)

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

Name: _____ Last 4 of SSN: _____

Address: _____ DOB: _____/_____/_____

Date of Crime: _____/_____/_____ Claim Number: _____

1. Dates of employment:	From: ____/____/____ To: ____/____/____
2. Hourly Wage: $ _____ Employment type: Full-time ☐ Part-time ☐	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 ☐
4. Total amount of wages lost due to victimization.	$ _____
5. Dates of paid leave: None ☐ Annual ☐ Sick ☐ Sick & Annual ☐ ☐ Other:_____	From: ____/____/____ To: ____/____/____
6. Disability pay:	Yes ☐ No ☐
If Yes, what type: Short-Term ☐ Long-Term ☐ Worker's Compensation ☐	
Amount:	$ _____
Dates of disability pay:	From: ____/____/____ To: ____/____/____

_____ _____
Company Name (print name) Employer (print name)

_____
Employer Signature

Date: _____/_____/_____ Telephone No.: _____-_____-_____

PLEASE NOTE:

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