saif Work. Life. Oregon.

Claim for lost earnings while attending required medical exam

Name of worker _____   Claim no. _____

Date of examination   _____

Name of doctor or hospital   _____

Date and time left work   _____

Date and time returned to work   _____

Working hours lost   _____

Hourly wage   _____

Net lost wages (after taxes and other deductions) _____

I certify the above information is correct.

_____
Signature   Date

Employer's verification

I certify that the above worker was absent from work for the period indicated and that the worker's net lost wages (after deductions) were $ _____.

_____
Employer signature   Date