

WAGE AUTHORIZATION

This form, signed by: _____ ,
(Employee's Name - Please Print)

will authorize: _____
(Name of Company(s))

to release all wage information and records pertaining to injuries sustained as a result of
_____ on or about _____

to **Townsend & Leedham Adjusters Ltd.** for the purpose of determining the appropriate information of an injury accident claim for insurance.

This authorization includes:

- All information in your possession regarding my rate of pay, hours worked, amount of overtime, commissions, vacation allowance, nature of my employment, time lost from work and other information which they may require.

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure. I understand that I may revoke this consent at any time.

Date of consent: _____ End date of consent (if any)*: _____

* Consent is no longer valid after this date.

Signature : _____

Witness : _____ Witness Signature : _____
(Please Print)

Townsend & Leedham Adjusters Ltd.