STATE OF CALIFORNIA

EMPLOYMENT VERIFICATION REPLY FORM

VCB-31-10030 (Rev. 05/2026)

CalVCB Application Number: _____

Was the victim employed by your company on the date of the incident? ☐ Yes ☐ No

If no, did the employee accept a job offer within 30 days before the incident? ☐ Yes ☐ No

If yes, please send a documented job offer with this completed form.

Employee Information

Full Name: _____ Social Security Number: _____

Company Name: _____ Federal Tax ID Number: _____

Company Address: _____

Job Title: _____ Hire Date (mm/dd/yyyy): _____

Employee Dates: *Start Date (mm/dd/yyyy):* _____ *End Date (mm/dd/yyyy):* _____

Employed on seasonal, temporary, contract or on-call basis? ☐ Yes ☐ No

If no longer employed, is the reason related to the incident? ☐ *Yes* ☐ *No* *Termination Date:* _____

Information About the Time Off Work

Dates missed due to this incident: (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____

Would the employee have been on layoff status at any time during their time off work?

☐ Yes, from (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____ ☐ No

Work Schedule Information

On what time basis is the employee scheduled to work? ☐ Full Time ☐ Part Time _____ hours per _____

On average, how many hours does the employee work and how are they scheduled?

_____ hours per ☐ Day ☐ Week ☐ Bi-Weekly ☐ Twice Monthly ☐ Monthly

Pay Rate Information

What is the employee's pay type? ☐ Salary ☐ Hourly ☐ Other _____

If other, please indicate how often the employee is paid?

_____ hours per ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Twice Monthly ☐ Monthly

If a school teacher indicate the pay rate: ☐ *12 months* ☐ *10 months*

CALIFORNIA VICTIM COMPENSATION BOARD
P.O. Box 3036 • Sacramento, CA 95812 • Phone: 800-777-9229 • www.victims.ca.gov

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Pay Rate Information continued

What is the employee's federal filing status? ☐ Single ☐ Married

What are the employee's federal exemptions, if any? _____

What is the employee's base payment rate? $ _____ per _____

What is the employee's average tip payment rate, if any? $ _____ per _____

Information About Paid Time Off

Was the employee paid for time off following the incident? ☐ Yes ☐ No

To your knowledge, did the employee collect SDI as a result of the incident? ☐ Yes ☐ No

Breakdown of amounts the employee was paid while off work due to this incident:

Sick Leave $ _____ Vacation/Annual PTO Leave $ _____

Catastrophic Leave $ _____ Employer Disability $ _____

Worker's Comp $ _____ Other (specify) $ _____

Information About Potential Reimbursement Sources

Was the employee injured while on the job? ☐ Yes ☐ No

Workers Compensation Insurance Carrier: _____

Address: _____

Claim Number: _____ Phone Number: _____

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct, and complete to the best of my knowledge and belief.

PRINTED NAME of the person completing this form: _____

Title: _____ Phone Number: _____

SIGNATURE of the person named above: _____ Date: _____

Please mail, email, or fax this Reply Form to:
VICTIM COMPENSATION BOARD, PO Box 3036 • Sacramento, California 95812-3036
documentreceivingsection@victims.ca.gov • Fax: 1-866-902-8669