Print Form

COMMANDING OFFICER'S
EMPLOYER CERTIFICATION FOR 37 U. S. C. 204(h)(I)
(USE ONLY IF MARINE FIT FOR MILITARY DUTY BUT REQUIRES COSMETIC ATTENTION)

NOTE TO THE EMPLOYER. Please complete the certification below. Your employee incurred an injury, illness, or disaese while on inactive/active duty with the Marine Corpss. This certificate must be updated EVERY 30 DAYS. Instructions provided at bottom of form.

DATE:

COMPANY NAME:

ADDRESS:

1. EMPLOYEE'S NAME: SOCIAL SECURITY NUMBER: is an employee.

2. This report is for the period: DATE: through DATE:

3. The member **LOST (wages, salaries, professional fees, tips):**

4. The employer DID receive compensation (income protection plan, vacation pay, sick leave):

5. TOTAL compensation LOST for the reported period (line 3 plus line 4): $0.00

EMPLOYER SIGNATURE:	POSITION:
	TELEPHONE NO:

EMPLOYER CERTIFICATION INSTRUCTIONS
EMPLOYER

1. This form is used to determine incapacitation payments from the U.S. Government on behalf of your emploee. The information on this form is used for no other purpose than determining your employer's incapacitation pay.

2. This form will be required when your employee takes leave .of their normal employment to resolve a service incurred condition.

3. The member will be compensated by the U. S. Government for income lost in pursuit of medial or dental care.

4. Please also ensure that the date of the report is after the last day of the reporting period. This form is used to report compensation actually lost or forefeited and is not a forecast of projected income.

ADMINISTRATION

1. All reported/non-reported income should be verified to ensure the figures are correct and accuracte.

2. Date of income lost should correspond with medical documentation.

3. Enter total amount lost in Block (5) of the pay request.

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