



Bord Measúnaithe
Díobhála Pearsanta
Personal Injuries
Assessment Board

CERTIFICATE OF LOSS OF EARNINGS

INJURIES BOARD CLAIM NUMBER: «Claim Number»

CLAIMANT NAME: _____ Date of Accident: _____

***PPS NUMBER:**

--	--	--	--	--	--	--	--	--

Period(s) to which losses relate: From: _____ To: _____
From: _____ To: _____
From: _____ To: _____

Gross Loss of Earnings in above period(s): € _____

LESS:

PAYE € _____

USC € _____

PRSI € _____

Any Sums received by claimant
under Employer Sickness Scheme etc
not funded by the claimant **

€ _____

Total deductions € _____

Net Loss of Earnings € _____

I certify that the amounts stated above are an accurate reflection of the net earnings loss incurred by the claimant during the period(s) mentioned.

Employers Name: _____

Employers Address: _____

Signature: _____

Title: _____

Date: ___/___/___ Company Stamp: _____

***Please ensure the PPS number section is completed**

**Payments received from the Dept. of Social Protection should not be included in the deductions above.

In certain circumstances, employees may have their payments from Dept. of Social Protection remitted directly to the employer. If this occurred in this instance, please tick this box: