WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE # _____

In order to determine the correct rate of compensation to be paid to the above injured party, please fill in the schedule below and return it promptly. This information is required by law and no agreement for payment of compensation can be made until it has been received. Please complete 52 weeks prior to date of accident.

Please describe allowances of any character made in lieu of wages that must be deemed a part of employee's earnings:

_____

_____

If the average weekly wage is not based on fifty-two weeks of earnings preceding the date of injury, please show your computation below:

_____

_____

_____

WEEKS	NO. DAYS	WEEK ENDING	GROSS WAGES		WEEKS	NO. DAYS	WEEK ENDING	GROSS WAGES	
1					27				
2					28				
3					29				
4					30				
5					31				
6					32				
7					33				
8					34				
9					35				
10					36				
11					37				
12					38				
13					39				
14					40				
15					41				
16					42				
17					43				
18					44				
19					45				
20					46				
21					47				
22					48				
23					49				
24					50				
25					51				
26					52				
							TOTAL PAID		

RATE PER DAY _____ PER HOUR _____ AVERAGE PER WEEK _____

I hereby certify that the above is a true and correct account, as taken from our timebooks or payroll records, of the wages paid to the above-named injured employee for the periods indicated.

Date _____ 20 _____

EMPLOYER _____

BY _____

TITLE _____

LB-0384 (rev. 5/95)