WAGE STATEMENT

Employee:_____ Employer:_____

Date of injury: _____ Claim #: _____

Date employed:_____ Social Security #:_____

Job title: _____ Class code: _____

Number of dependents claimed on withholding statement: _____

Weekly cost of fringes **maintained during disability:** _____

eekly cost of fringes **discontinued during disability:**_____

Weekly cost of **entire fringe benefit package:** _____

Starting with the week immediately preceding the date of injury, list gross wages paid in each of the previous 52 weeks. If no wages were paid during a week, please enter "none" under Gross Wages Paid.

	Week Ending Mo/Day/Yr	Days Worked	Gross Wages Paid		Week Ending Mo/Day/Yr	Days Worked	Gross Wages Paid
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 gross wages paid:_____ Number of weeks used in calculation:_____

Completed by:_____ Date:_____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

mcim