

# 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**: \_\_\_\_\_

Weekly 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.*

