State of Rhode Island
Department of Labor and Training
Division of Workers' Compensation
1511 Pontiac Avenue
Cranston, RI 02920

Forms Revised January, 2003

Form Number	Form Title
DWC-01	Employer's First Report of Alleged Occupational Injury or Disease
DWC-02	Memorandum of Agreement
DWC-03F	Wage Statement, Full Time
DWC-03P	Wage Statement, Part-Time
DWC-03S	Wage Statement, Seasonal
DWC-04	Employee's Certificate of Dependency Status
DWC-05	Suspension Agreement and Receipt
DWC-20	Non-Prejudicial Agreement
DWC-22	Report of Indemnity Payment
DWC-24	Mutual Agreement
DWC-25	Report of Earnings
DWC-30	Wage Transcript
DWC-31	Employee's Objection to Wage Transcript
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DWC-50	Itemized Statement of Compensation
DWC-51	Report of Specific Payment

State of Rhode Island
Department of Labor and Training
Division of Workers' Compensation
1511 Pontiac Avenue
Cranston, RI 02920

Forms Revised January, 2003

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Employee's Objection to Wage Transcript	DWC-31
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Wage Statement, Full-Time	DWC-03F
Wage Statement, Part-Time	DWC-03P
Wage Statement, Seasonal	DWC-03S
Wage Transcript	DWC-30

State of Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. _____

Insurer File No.

1. EMPLOYER LOCATION:	**2. EMPLOYER NAMED ON WC INSURANCE POLICY:** ☐ **SAME AS BLOCK 1**
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext. Type of Business	Phone Ext.
RI Unemployment Ins. No. NAICS	WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.

5. EMPLOYEE INFORMATION:		**6. MEDICAL INFORMATION:**
SSN ☐ Male ☐ Female		Treatment Facility
Name		Address
Address		City, State, Zip
City, State, Zip		Phone Ext.
Phone	Date of Birth	**7. WITNESS INFORMATION:**
Occupation	Date Hired	Name Phone
State of Hire	Preferred Language of Employee: O English O Spanish O Portuguese O Other:	

8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐ AM ☐ PM	
Time employee began work ☐ AM ☐ PM	
1. First full day lost from work ☐ NONE LOST	
2. Date returned to work (if appropriate)	List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
3. Date employer notified of injury	
If fatal - **REPORT WITHIN 48 HOURS** - Date of death	

Place where injury/illness occurred: ☐ At employer location listed in Block 1 **OR** Complete address where accident occurred:

Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No

If Yes, date employer first notified of medical treatment or time lost

Category(ies) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown

Print Name of Report Preparer	Date Prepared	Phone & Extension
Print Name of Employer Contact Person OR ☐ Same as above		Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

State of Rhode Island
MEMORANDUM OF AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No.

1. EMPLOYEE:	**2. EMPLOYER:**
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number
Injury date:	List injured body parts and nature of injury:
First date of first disability:	
Place where injury occurred:	

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☐ Temporary Partial as of _____

☐ Death Benefits/Date of Death _____

Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☐ Married

Number of Exemptions _____

AWW (include bonus/no OT) _____

Average Overtime Amount _____

AWW including Overtime _____

Spendable Base Wage _____

Base Compensation Rate _____

Number of Dependents _____

Weekly Dependency Rate _____

Total Weekly Rate _____

7. DATE OF INITIAL PAYMENT UNDER MOA: _____

Does employee have other employers? ☐ Yes ☐ No If yes, attach a wage statement from each employer.

Is this a recurrence of a previous injury? ☐ Yes ☐ No Previous disability end date: _____

Has the employee worked at least 26 weeks prior to this recurrence? ☐ Yes ☐ No If yes, a new wage statement is required.

Signature: Date:

Print Name: RI Adjuster License Number: Phone & Extension:

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:

YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

State of Rhode Island
FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

EMPLOYEE INFORMATION:

SSN _____

Name _____

Hired for_____ hours each week (☐ Approximate)

Are these supplemental wages? ☐ Yes ☐ No

If yes, supplemental employer name: _____

Maximum no. of exemptions_____ ☐ Single ☐ Married

CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

EMPLOYED LESS THAN 2 WEEKS:

If Yes:	**OR:**
1. List agreed upon hourly wage _____	
2. Number of hrs. per week for full-time employees _____	Give average weekly for same or similar employment: _____
3. Multiply #1 by #2 for average weekly wage	

EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
Total number usable weeks:		Total earnings:	

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 13 weeks	
2. Total number usable weeks	
3. Divide total earnings by number of usable weeks	
4. Average bonus (Block 3 in BONUS AND OT)	
5. Add 3 and 4 for AWW excluding Overtime	$
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	$

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

For instructions visit our web site: www.dlt.ri.gov/wc

State of Rhode Island
PART-TIME WAGE STATEMENT (Hired for less than 20 hours per week)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

EMPLOYEE INFORMATION:

SSN _____

Name _____

Hired for_____ hours each week (☐ Approximate)

Are these supplemental wages? ☐ Yes ☐ No

If yes, name of supplemental employer_____

Maximum no. of exemptions_____ ☐ Single ☐ Married

CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator_____

Injury date _____

Incapacity date _____

Hire date _____

EMPLOYED LESS THAN 2 WEEKS:

If Yes:

1. List agreed upon hourly wage _____
2. Number of hrs. per week for part-time employees _____
3. Multiply #1 by #2 for average weekly wage

OR:

Give average weekly for same or similar employment: _____

EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS**. Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 26 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
Total number usable weeks:		Total earnings:	

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 26 weeks	
2. Total number usable weeks	
3. Divide total earnings by number of usable weeks	
4. Average bonus (Block 3 in BONUS AND OT)	
5. Add 3 and 4 for AWW excluding Overtime	$
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	$

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

For instructions visit our web site: www.dlt.ri.gov/wc

State of Rhode Island
SEASONAL WAGE STATEMENT (Hired for 16 weeks or less)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____

Name _____

Maximum no. of exemptions_____ ☐ Single ☐ Married

Wages for how many employers are listed below? _____

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

List 52 CONSECUTIVE weeks of gross wages for *any* employment held by this person within the 52 week period.

Week Number	Week Ending Date	Gross Wages	Week Number	Week Ending Date	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 earnings:			Total earnings:

1. Combine total earnings listed _____
2. Divide total earnings by 52 ÷ 52
3. Average Weekly Wage $ _____

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

For instructions visit our web site: www.dlt.ri.gov/wc

State of Rhode Island ☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYEE'S CERTIFICATE OF DEPENDENCY STATUS

Department of Labor and Training, Division of Workers' Compensation

Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____ ☐ Male ☐ Female

Name _____

Address _____

City, State, Zip _____

Phone _____ Date of Birth _____

2. CLAIM INFORMATION:

Employer _____

Claim Administrator _____

Address _____

City, State, Zip _____

Date of Injury _____ Date of Incapacity _____

THE EMPLOYEE MUST COMPLETE ALL REQUIRED INFORMATION:

Please return this form to your employer's workers' compensation Claim Administrator. If they do not receive this completed form promptly, it may result in a delay of your claim.

3. MARITAL STATUS & EXEMPTION INFORMATION: (Needed to calculate your weekly compensation payment)

Were you married at the time of your injury? ☐ Yes ☐ No If Yes, Spouse Name: _____

If Yes, does your spouse work? ☐ Yes ☐ No Spouse SSN**: _____

Please put an appropriate number in each box -- you are entitled to one exemption for yourself and one for your spouse.

Yourself	1
Spouse	
Total Dependents Listed **Below**	
Total Other	
Total Number of Exemptions (Add all of the above)	

(**Other**: You may be entitled to additional exemptions if you or your spouse are over 65 or blind. Please contact your employer's workers' compensation Claim Administrator for further information)

4. DEPENDENT INFORMATION List each dependent child below. A dependent child includes:

- ~ Children under the age of eighteen living with you or whom you were required to support at the time of the injury
- ~ Children you support who are over eighteen but who are mentally or physically incapacitated from earning
- ~ Children under the age of twenty-three who are full-time students at an accredited educational facility

Dependent's Name:	Dependent's Date of Birth:	Dependent's Social Security Number:**	If over 18 and under 23, Full-Time Student?	
1.			☐ Yes	☐ No
2.			☐ Yes	☐ No
3.			☐ Yes	☐ No
4.			☐ Yes	☐ No
5.			☐ Yes	☐ No
6.			☐ Yes	☐ No
7.			☐ Yes	☐ No
8.			☐ Yes	☐ No
9.			☐ Yes	☐ No
10.			☐ Yes	☐ No

Employee Signature: Date:

**** Completion of the Social Security Number for Spouse and Dependents is optional.**

Employee Note: **DO NOT return this form to the Department of Labor and Training - RETURN TO Claim Administrator**

State of Rhode Island
SUSPENSION AGREEMENT AND RECEIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

We agree that weekly compensation which began on _____(date of incapacity) will end as of _____(date paid through). Payment of medical bills related to this injury may continue. Completing and signing this form does not prevent the employee from claiming future weekly compensation benefits in the event that the employee is unable to work due to this injury.

Employee Signature: Date:

Employer or Insurer Signature: Date:

State of Rhode Island
NON-PREJUDICIAL AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No.

1. EMPLOYEE:	**2. EMPLOYER:**
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number
Injury date:	List injured body parts and nature of injury:
First date of first disability:	
Place where injury occurred:	

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☐ Temporary Partial as of _____

☐ Death Benefits/Date of Death _____
Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☐ Married

Number of Exemptions _____
AWW (include bonus/no OT) _____
Average Overtime Amount _____

AWW including Overtime _____
Spendable Base Wage _____
Base Compensation Rate _____

Number of Dependents _____
Weekly Dependency Rate _____
Total Weekly Rate _____

7. DATE OF INITIAL PAYMENT: _____

Does employee have other employers? ☐ Yes ☐ No If yes, attach a wage statement from each employer.
Is this a recurrence of a previous injury? ☐ Yes ☐ No Previous disability end date: _____
Has the employee worked at least 26 weeks prior to this recurrence? ☐ Yes ☐ No If yes, a new wage statement is required.

Signature: Date:

Print Name: RI Adjuster License Number: Phone & Extension:

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:
YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

State of Rhode Island
REPORT OF INDEMNITY PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No.

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:	YOU ***MUST*** CHECK ONE OF THE FOLLOWING:
☐ **TERMINATION OF BENEFITS UNDER NON-PREJUDICIAL AGREEMENT***	☐ **INTERIM**
☐ **PAYMENT UNDER MEMO OF AGREEMENT, ORDER OR DECREE**	☐ **FINAL:** Date of last weekly indemnity payment: _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Date of Birth _____
Maximum no. of exemptions _____ ☐ Single ☐ Married

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Date of death _____ ☐ NOT work-related

3. RATE INFORMATION:

AWW including Overtime _____
Spendable Base Wage _____
Base Compensation Rate _____
AWW (include bonus/no OT) _____
Total Cost of Living Adjustment(s) _____
Weekly Dependency Rate _____

4. WEEKLY COMPENSATION:

Indicate Payment Type	Payment period Date from	Payment period Date through	Number of Weeks & Days	Total Weekly Rate	Variable Partial Total Spendable	Compensation Paid	☐ Settlement ☐ Deny&Dismiss
☐TI ☐PI ☐DB							Amount:
☐TI ☐PI ☐DB							Decree No.
☐TI ☐PI ☐DB							Decree Date

5. WEEKLY COMPENSATION for Variable Partial Payments: (Complete information above also)

Week Ending	Gross Earnings	Spendable Earnings	Amount Paid	Week Ending	Gross Earnings	Spendable Earnings	Amount Paid

Signature: Date:

Print Name: RI Adjuster License Number: Phone & Extension:

***THE FOLLOWING NOTICE IS FOR EMPLOYEES TERMINATED UNDER A NON-PREJUDICIAL AGREEMENT ONLY**

Weekly compensation payments have stopped. The insurer/employer has not accepted liability for this claim. If you wish to protect any rights you may have under the Workers' Compensation Act, including possible entitlement to continued or future weekly compensation payments or payment of medical expenses, a petition must be filed with the Workers' Compensation Court within two (2) years from the first date of incapacity.

State of Rhode Island
MUTUAL AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

This form may be used pursuant to Rhode Island General Law § 28-35-6(b) to amend a Memorandum of Agreement, Order or Decree regarding a Workers' Compensation claim. This form cannot be used for commencement or termination of weekly benefits.

YOU *MUST* ATTACH A COMPLETED REPORT OF INDEMNITY PAYMENT (DWC-22) TO THIS MUTUAL AGREEMENT.

3. INDICATE THE ACTION(S) OF THIS MUTUAL AGREEMENT:

☐ Change total average weekly wage from $ _____ to $ _____
☐ Change weekly spendable base wage to $ _____ as of _____ (date)
☐ Change weekly compensation rate to $ _____ as of _____ (date)
☐ Change marital status to ☐ Single ☐ Married as of _____ (date)
☐ Change maximum number of exemptions to _____ as of _____ (date)
☐ Change number of dependents to _____ as of _____ (date)
☐ Change nature of injury and/or affected body part to _____
☐ Modify from total to partial incapacity as of _____ (date)
☐ Modify from partial to total incapacity as of _____ (date)
☐ Suitable Alternative Employment (Attach SAE Offer) as of _____ (date)
☐ Other (Specify) _____

DO NOT USE THIS FORM FOR A SPECIFIC INJURY (DISFIGUREMENT, LOSS OF USE, HEARING LOSS); USE THE REPORT OF SPECIFIC PAYMENT (DWC-51).

Employee Signature:	Date:	Employer/Insurer Signature:	Date:

State of Rhode Island
REPORT OF EARNINGS

Department of Labor and Training, Division of Workers' Compensation
Phone (401) 462-8100 TDD (401) 462-8006

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM ADMINISTRATOR:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

This report covers the time period from: _____ **to:** **PRESENT**

3. NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION:

If you are receiving weekly workers' compensation benefits, YOU MUST REPORT ANY EARNINGS YOU RECEIVE TO THE CLAIM ADMINISTRATOR THAT IS PAYING YOUR BENEFITS. "Earnings" include any cash, wages, or salary received from self-employment or from any employer other than the employer where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (for example: a building custodian receiving a rent-free apartment).

Your endorsement on a benefit check or deposit of the check into an account is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

You must report any work for any business or person, even if the business or person lost money or if profits or income were reinvested or paid to others. If you performed any duties for any business or person for which you were not paid, you must show a rate of pay of what it would have cost the employer to hire someone to perform the work you did, even if your work was for yourself, a relative, or friend.

You are NOT entitled to workers' compensation benefits for any time you are imprisoned as a result of a criminal conviction.

4. Employee Complete:

1. Did you receive earnings or payments during the above period? State YES or NO: _____
2. Did you perform non-paid work activities during the above period? State YES or NO: _____

If you answered NO to BOTH questions, sign, date and return the form to the CLAIM ADMINISTRATOR above.

If you answered YES to EITHER question, complete the following:

Employer Name _____ Self-Employed? ☐ Yes ☐ No

Address _____ Nature of business _____

City _____ State _____ Zip Code _____ Phone _____

5. Earnings Received:

Report pre-tax earnings. Include any cash, bonus, commission, and the cash value of any payment received in any form other than cash. *Attach additional pages if necessary.*

Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:

Failure to report earnings as defined will subject you to criminal prosecution and civil liability including the suspension or forfeiture of your benefits. This form MUST BE SIGNED, DATED and returned to the Claim Administrator -- EVEN IF YOU HAVE NO EARNINGS.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

For instructions visit our web site: www.dlt.ri.gov/wc

State of Rhode Island
WAGE TRANSCRIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

This form will not be accepted for filing unless all information is completed.

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

3. INSURER COMPLETE:

This wage transcript is submitted to support a:

☐ **Discontinuation of benefits.** The employee has returned to work at a wage equal or greater than he or she earned at the time of the injury.

☐ **Reduction of benefits.** The employee has returned to work at a wage less than he or she earned at the time of the injury.

Date benefits were discontinued or reduced: _____

Pre-injury average weekly wage, **not** including overtime: _____

4. EMPLOYER COMPLETE:

Post-Injury Earning Information -- WEEKS MUST BE CONSECUTIVE

	Period Start Date	Period End Date	Number of Hours Worked	Payment Rate	Amount of Earnings
Week 1					
Week 2					

Employer Name: _____

Address: _____

City, State Zip: _____ Phone: _____

Employer/Insurer Signature: Date:

State of Rhode Island
EMPLOYEE'S OBJECTION TO WAGE TRANSCRIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

The employee objects to the discontinuance or reduction of workers' compensation benefits pursuant to RIGL Section 28-35-47 and requests a review by the Workers' Compensation Court, pursuant to RIGL Section 28-35-51.

Employee: Date:

State of Rhode Island
Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 (401) 462-8100 TDD (401) 462-8006

NOTICE TO EMPLOYEES
REGARDING THE EFFECT OF ENDORSEMENT OF BENEFIT CHECK

You are presently receiving or have filed a claim to receive workers' compensation benefits. You should know and are hereby advised that by endorsing your workers' compensation benefit check or upon deposit of your workers' compensation check into an account, you are declaring that you are receiving benefits under the Workers' Compensation Act. In other words, your endorsement on a weekly benefit check is your statement that you are entitled to receive workers' compensation benefits for that week under the Workers' Compensation Act and have made no false claims or statements or concealed any material fact.

Furthermore, if you can return to any work and receive earnings, which includes wages, salary, commissions, bonuses, cash, and/or any other compensation other than money, YOU MUST REPORT THESE EARNINGS TO YOUR EMPLOYER'S CLAIM ADMINISTRATOR IMMEDIATELY. If you endorse a benefit check that is for a week in which you had earnings AND YOU FAIL TO REPORT THESE EARNINGS, YOU MAY BE PROSECUTED BY THE ATTORNEY GENERAL AND SENT TO PRISON.

You are NOT ENTITLED to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

State of Rhode Island
ITEMIZED STATEMENT OF COMPENSATION

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____ Incapacity date _____
Date of death _____ ☐ Work-related OR Not ☐

3. ☐ **Incident Only--**No payments made. Complete Section 8 and return to DLT ***only*** at above address. ***All others continue below.***

4. NONPAYMENT OF WEEKLY INDEMNITY ONLY: Check correct box and complete appropriate information on remainder of form.

☐ **Medical Only*** *Payment info must be listed below ☐ **Federal Jurisdiction** ☐ **Salary Continuation** ☐ **Denied**
☐ **Death--**Liability established; no dependents. Payment made to WCAF ☐ **Other:**

Do **NOT** use *Other* if claim is *Denied*

5. DIAGNOSIS:

Primary Written Diagnosis	ICD Code:
Secondary Written Diagnosis	ICD Code:

6. PAYMENT INFORMATION: (List total amount paid for each appropriate item in both columns) **DATE OF FIRST INDEMNITY PAYMENT:** _____

Temporary Partial		Hospital/Treatment Center	
Temporary Total		Independent Medical Exams	
Permanent Total		Pharmaceutical	
Weekly Death Benefits		Chiropractic	
Burial		Diagnostic Testing	
Specific - Disfigurement		Attorney Fees Awarded by Court	
Specific - Loss of Use		Penalties/Interest	
Vocational Rehabilitation		WC Administrative Fund (WCAF)	
Physical Therapy		Settlement	
Occupational Therapy		Deny & Dismiss	
Psychological Services		Other Payments:	
Physicians		Subrogation	☐ Yes ☐ No

7. RETURN TO EMPLOYMENT: Did the employee return to employment? ☐ Yes ☐ No ☐ Unknown

If yes, was it with the ☐ same employer OR a ☐ different employer ☐ Unknown Date Returned: ☐ Unknown

8. THIS REPORT WAS PREPARED BY: **PLEASE PRINT**

Name	RI Adjuster License Number	
Company Name		
Address		
City	State	Zip Code
Telephone	Extension	Email

Signature _____ Date _____

Distribution: DLT, Division of Workers' Compensation; Employee and Attorney; Employer

State of Rhode Island
REPORT OF SPECIFIC PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8084

DWC No. _____

Insurer File No. _____

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:

☐ **LOST TIME** ☐ **NO LOST TIME** ☐ **FEDERAL JURISDICTION**

1. EMPLOYEE:	**2. EMPLOYER:**
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number

5. CLAIM INFORMATION:

Injury date _____ Incapacity date (if appropriate) _____

Average Weekly Wage (including OT) _____ Weekly Specific Rate _____

Specific paid by: ☐ Court Order Date: _____ Number: _____ **OR** ☐ Agreement of the Parties

Description of Injury/Specific: _____

Attorney Fee: _____

6. SPECIFIC PAYMENT INFORMATION:

Indicate Payment Type	Body Part	Percent of Loss	Number of Weeks	Amount Paid	Date Paid
☐ disfigurement ☐ loss of use					
☐ disfigurement ☐ loss of use					
☐ disfigurement ☐ loss of use					

Hearing Loss			Total/Partial Deafness		Number of Weeks	Amount Paid	Date Paid
Left Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			
Right Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			

Employee Signature: (Not required for Court Order)	Date:	Employer/Insurer Signature:	Date:

For instructions visit our web site: www.dlt.state.ri.us/wc