Employee's Certificate of Dependency Status

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

☐ Check if this is a corrected report

Claim Administrator File Number:

1. Employee information:		**2. Claim information:**	
SSN:	XXX - XX -	Employer name	
Name		Claim Administrator	
Address		Address	
City, St, Zip		City, St, Zip	
Phone		Injury Date	
Date of Birth		Incapacity Date	

Employee: complete this form and return it to the Claim Administrator.
This information is needed to calculate your compensation rate.

3. Marital Status At the time of the injury the employee was ☐ Single ☐ Married

☐ Spouse works ☐ Spouse does not work Spouse's name

4. Number of Federal Exemptions ☐ Enter the maximum number of Federal Exemptions you are allowed to claim for Federal income tax. Include yourself, your spouse, your dependents, and any other exemptions.

5. Dependents

A dependent for workers' compensation includes children you support who are:

- Under age 18, or age 18 to 23 and a full time student
- Mentally or physically incapacitated from earning at any age

Dependent's Name	Date of Birth	Relationship	Full time student?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Employee's Signature Date