

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

Forms Revised January, 2003

<b>Form Number</b>	<b>Form Title</b>
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
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State of Rhode Island  
Department of Labor and Training  
Division of Workers' Compensation  
1511 Pontiac Avenue  
Cranston, RI 02920

Forms Revised January, 2003

<b>Form Title</b>	<b>Form Number</b>
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Employee's Objection to Wage Transcript	DWC-31
Employer's First Report of Alleged Occupational Injury or Disease	DWC-01
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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

DWC No. \_\_\_\_\_

PO Box 20190, Cranston, RI 02920-0942

Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

Insurer File No. \_\_\_\_\_

<b>1. EMPLOYER LOCATION:</b> FEIN Name Address City, State, Zip Phone Ext. Type of Business RI Unemployment Ins. No. NAICS				<b>2. EMPLOYER NAMED ON WC INSURANCE POLICY:</b> <input type="checkbox"/> SAME AS BLOCK 1 FEIN Name Address City, State, Zip Phone Ext. WC Policy Number			
<b>3. INSURANCE COMPANY NAMED ON WC POLICY:</b> FEIN Name Address Address City, State, Zip Phone Ext.				<b>4. CLAIM ADMINISTRATOR:</b> <input type="checkbox"/> SAME AS BLOCK 3 FEIN Name Address Address City, State, Zip Phone Ext.			
<b>5. EMPLOYEE INFORMATION:</b> SSN <input type="checkbox"/> Male <input type="checkbox"/> Female Name Address City, State, Zip Phone Date of Birth Occupation Date Hired State of Hire Preferred Language of Employee: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Portuguese <input type="radio"/> Other:				<b>6. MEDICAL INFORMATION:</b> Treatment Facility Address City, State, Zip Phone Ext.			
<b>8. INJURY INFORMATION:</b> Injury Date Time injury occurred <input type="checkbox"/> AM <input type="checkbox"/> PM Time employee began work <input type="checkbox"/> AM <input type="checkbox"/> PM 1. First full day lost from work <input type="checkbox"/> NONE LOST 2. Date returned to work (if appropriate) 3. Date employer notified of injury If fatal - <b>REPORT WITHIN 48 HOURS</b> - Date of death				<b>7. WITNESS INFORMATION:</b> Name Phone What was person doing when injured? List injured body parts and nature of injury:(ex: Broken left finger, lower back strain) Complete address where accident occurred: Place where injury/illness occurred: <input type="checkbox"/> At employer location listed in Block 1 OR Was this injury previously an incident-only with no medical treatment and no time lost? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date employer first notified of medical treatment or time lost Category(ies) of injury or illness: <input type="radio"/> Injury <input type="radio"/> Illness <input type="radio"/> Occupational Disease <input type="radio"/> Repetitive Trauma <input type="radio"/> Occupational Hearing Loss <input type="radio"/> Unknown			
<b>Print Name of Report Preparer</b> _____		Date Prepared _____		Phone & Extension _____			
<b>Print Name of Employer Contact Person OR</b> <input type="checkbox"/> Same as above				Phone & Extension _____			

<b>DWC:</b>	County	Time A	Time W	OCC	Nature	Part	Source	Type	
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**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. \_\_\_\_\_

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

**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 \_\_\_\_\_ Number of Dependents \_\_\_\_\_  
 Spendable Base Wage \_\_\_\_\_ Weekly Dependency Rate \_\_\_\_\_  
 Base Compensation Rate \_\_\_\_\_ Total Weekly Rate \_\_\_\_\_

**7. DATE OF INITIAL PAYMENT UNDER MOA:** \_\_\_\_\_

Does employee have other employers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach a wage statement from each employer.
Is this a recurrence of a previous injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous disability end date: _____
Has the employee worked at least 26 weeks prior to this recurrence?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:**

<p><b>If Yes:</b></p> <p>1. List agreed upon hourly wage _____</p> <p>2. Number of hrs. per week for full-time employees _____</p> <p>3. Multiply #1 by #2 for average weekly wage _____</p>	<p><b>OR:</b></p> <p>Give average weekly for same or similar employment: _____</p>
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**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:				BONUS AND OVERTIME CALCULATION:	
Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)		
1				Number of weeks employed (up to 52)	Block 1
2				Total <b>BONUS</b> amount paid in past 52 weeks	Block 2
3				Divide Block 2 by Block 1 for average bonus	Block 3
4				Total <b>OVERTIME</b> amount paid in past 52 weeks	Block 4
5				Divide Block 4 by Block 1 for average overtime	Block 5
6					
7					
8					
9					
10					
11					
12					
13					
Total number usable weeks:		Total earnings:		<b>CALCULATION OF AVERAGE WEEKLY WAGE (AWW):</b>	
				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: _____
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**PART-TIME WAGE STATEMENT** (Hired for less than 20 hours per week)

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:**

<p><b>If Yes:</b></p> <p>1. List agreed upon hourly wage _____</p> <p>2. Number of hrs. per week for part-time employees _____</p> <p>3. Multiply #1 by #2 for average weekly wage _____</p>	<p><b>OR:</b></p> <p>Give average weekly for same or similar employment: _____</p>
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**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:				BONUS AND OVERTIME CALCULATION:	
Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)		
1				Number of weeks employed (up to 52)	Block 1
2				Total <b>BONUS</b> amount paid in past 52 weeks	Block 2
3				Divide Block 2 by Block 1 for average bonus	Block 3
4					
5				Total <b>OVERTIME</b> amount paid in past 52 weeks	Block 4
6					
7					
8					
9					
10					
11				Divide Block 4 by Block 1 for average overtime	Block 5
12					
13				CALCULATION OF AVERAGE WEEKLY WAGE (AWW):	
14				1. Total earnings from 26 weeks	_____
15				2. Total number usable weeks	_____
16				3. Divide total earnings by number of usable weeks	_____
17				4. Average bonus (Block 3 in BONUS AND OT)	_____
18				5. Add 3 and 4 for AWW excluding Overtime	\$ _____
19				6. Average overtime (Block 5 in BONUS AND OT)	_____
20					
21				7. Add 5 and 6 for Total Average Weekly Wage	\$ _____
22					
23					
24					
25					
26					
Total number usable weeks:		Total earnings:			

Print Preparer Name: \_\_\_\_\_ Date: \_\_\_\_\_      Print Adjuster Name: \_\_\_\_\_ Date: \_\_\_\_\_

**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  $\div 52$  \_\_\_\_\_

3. Average Weekly Wage \$ \_\_\_\_\_

Print Preparer Name: _____	Date: _____	Print Adjuster Name: _____	Date: _____
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# Employee's Certificate of Dependency Status

Check if this is a corrected report

State of Rhode Island

Department of Labor and Training

Division of Workers' Compensation

P. O. Box 20190

Cranston, RI 02920-0942

Phone (401) 462-8100 [www.dlt.ri.gov/wc](http://www.dlt.ri.gov/wc)

DWC claim number

Claim Administrator  
File Number

1. Employee information:		2. Claim Information:	
SSN: XXX-XX-	<input type="checkbox"/> Male <input type="checkbox"/> Female	Employer Name	
Name		Claim Administrator	
Address		Address	
City, ST Zip		City, ST Zip	
Phone	Date of Birth	Injury Date	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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee's Signature		Date	
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**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. \_\_\_\_\_

<b>1. EMPLOYEE:</b> SSN Name Address Address City, State, Zip Phone _____ Date of Birth _____	<b>2. EMPLOYER:</b> FEIN Name Address Address City, State, Zip Phone _____ Ext. _____
<b>3. INSURANCE COMPANY NAMED ON WC POLICY:</b> FEIN Name Address Address City, State, Zip Phone _____ Ext. _____ RI License Number _____	<b>4. CLAIM ADMINISTRATOR:</b> <input type="checkbox"/> <b>SAME AS BLOCK 3</b> FEIN Name Address Address City, State, Zip Phone _____ Ext. _____ 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 \_\_\_\_\_ Payable to: \_\_\_\_\_  Death Benefits/Date of Death \_\_\_\_\_

Temporary Partial as of \_\_\_\_\_  Permanent Total as of \_\_\_\_\_

**6. RATE INFORMATION:**  Single  Married Number of Exemptions \_\_\_\_\_  
AWW (include bonus/no OT) \_\_\_\_\_  
Average Overtime Amount \_\_\_\_\_

AWW including Overtime \_\_\_\_\_ Number of Dependents \_\_\_\_\_

Spendable Base Wage \_\_\_\_\_ Weekly Dependency Rate \_\_\_\_\_

Base Compensation Rate \_\_\_\_\_ Total Weekly Rate \_\_\_\_\_

**7. DATE OF INITIAL PAYMENT:** \_\_\_\_\_

Does employee have other employers? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach a wage statement from each employer.
Is this a recurrence of a previous injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous disability end date: _____
Has the employee worked at least 26 weeks prior to this recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> 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:**  
 TERMINATION OF BENEFITS UNDER NON-PREJUDICIAL AGREEMENT\*  
 PAYMENT UNDER MEMO OF AGREEMENT, ORDER OR DECREE

**YOU *MUST* CHECK ONE OF THE FOLLOWING:**  
 INTERIM  
 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	<input type="checkbox"/> Settlement <input type="checkbox"/> Deny&Dismiss
<input type="checkbox"/> TI <input type="checkbox"/> PI <input type="checkbox"/> DB							Amount:
<input type="checkbox"/> TI <input type="checkbox"/> PI <input type="checkbox"/> DB							Decree No.
<input type="checkbox"/> TI <input type="checkbox"/> PI <input type="checkbox"/> 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: _____
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**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:						

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: \_\_\_\_\_

**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.

<input type="checkbox"/> <b>Medical Only*</b> <small>*Payment info must be listed below</small>	<input type="checkbox"/> <b>Federal Jurisdiction</b>	<input type="checkbox"/> <b>Salary Continuation</b>	<input type="checkbox"/> <b>Denied</b>	Do <b>NOT</b> use <i>Other</i> if claim is <i>Denied</i>
<input type="checkbox"/> <b>Death</b> --Liability established; no dependents. Payment made to WCAF	<input type="checkbox"/> <b>Other:</b> _____			

**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	<input type="checkbox"/> Yes <input type="checkbox"/> 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 \_\_\_\_\_

**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

<p><b>1. EMPLOYEE:</b> SSN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Date of Birth _____</p>	<p><b>2. EMPLOYER:</b> FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____</p>
<p><b>3. INSURANCE COMPANY NAMED ON WC POLICY:</b> FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____ RI License Number _____</p>	<p><b>4. CLAIM ADMINISTRATOR:</b>      <input type="checkbox"/> SAME AS BLOCK 3 FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____ RI License or Self-Insurance Number _____</p>

**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
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					

Hearing Loss		Total/Partial Deafness		Number of Weeks	Amount Paid	Date Paid
Left Ear	<input type="checkbox"/> occupational <input type="checkbox"/> traumatic	<input type="checkbox"/> total	<input type="checkbox"/> partial			
Right Ear	<input type="checkbox"/> occupational <input type="checkbox"/> traumatic	<input type="checkbox"/> total	<input type="checkbox"/> partial			

<p>Employee Signature: _____ Date: _____ (Not required for Court Order)</p>	<p>Employer/Insurer Signature: _____ Date: _____</p>
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