

**Mutual Agreement**

RI Department of Labor and Training, Division of Workers' Compensation  
 PO Box 20190, Cranston, RI 02920-0942 www.dlt.ri.gov/wc  
 Phone 401-462-8100 Fax 401-462-8105

Claim Administrator Claim Number
----------------------------------

Employee Information			Employer Information
SSN or ID	Date of Birth		Employer Business Name
Last Name	First Name	Initial	Insurer Business Name
Date of Injury	Date of Death		Claims Administrator Business Name

This form may be used under RIGL § 28-35-6(b) to amend a Memorandum of Agreement, Order or Decree on a workers' compensation claim. This form cannot be used to start or end weekly benefits.

Amendment to Memorandum of Agreement. Indicate the change.			
<input type="checkbox"/> Change employee's marital status to	<input type="checkbox"/> Single	<input type="checkbox"/> Married	effective date: _____
<input type="checkbox"/> Change the total average weekly wage to	\$ _____		effective date: _____
<input type="checkbox"/> Change the weekly spendable base wage to	\$ _____		effective date: _____
<input type="checkbox"/> Change the weekly compensation rate to	\$ _____		effective date: _____
<input type="checkbox"/> Change maximum number of eligible exemptions	to _____		effective date: _____
<input type="checkbox"/> Change number of dependents	to _____		effective date: _____
<input type="checkbox"/> Modify from total to partial incapacity			effective date: _____
<input type="checkbox"/> Modify from partial to total incapacity			effective date: _____
<input type="checkbox"/> Suitable Alternative Employment (offer attached)			effective date: _____
<input type="checkbox"/> Change nature of injury and/or affected body part to	_____		
<input type="checkbox"/> Other (specify)	_____		

Specific Injury Agreement							
The injured worker and the Claims Administrator representing the Insurer and Employer agree on the specific injury or injuries stated here.							
Disfigurement: Body Part		Weeks	Weekly Rate	Amount Paid	Date Paid		
Loss of Use: Body Part		Percent	Weeks	Weekly Rate	Amount Paid	Date Paid	
Body Part	Type of Hearing Loss		Percent	Weeks	Weekly Rate	Amount Paid	Date Paid
<input type="checkbox"/> Left	<input type="checkbox"/> Occupational	<input type="checkbox"/> Traumatic					
<input type="checkbox"/> Right	<input type="checkbox"/> Occupational	<input type="checkbox"/> Traumatic					
<input type="checkbox"/> Both	<input type="checkbox"/> Occupational	<input type="checkbox"/> Traumatic					

Signatures of Parties to this Agreement			
Employee Signature	Date	Claim Administrator Signature	Date