ATHENS ADMINISTRATORS

STATEMENT OF WAGES

Employee:
Employer:
Claim No.:
Date of Injury:

Please give an exact statement of all payroll earnings for above employee for the **TWELVE** (12) **MONTHS** PRECEDING THE INJURY. Please break down bi-weekly, and indicate broken periods. Failure to provide this information may result in benefits being paid at maximum rate 30 days after the injury.

From Date	To Date	Occupation	Rate of Pay	Hrs. Worked	Gross Amount Earned		From Date	To Date	Occupation	Rate of Pay	Hrs. Worked	Gross Amount Earned	
TOTAL			CARRIED FORWARD		$		TOTAL			GRAND TOTAL		$	

PLEASE COMPLETE QUESTIONS BELOW

1. Is any other type of compensation provided to your employee, such as meals, transportation or housing? ☐ yes ☐ no
   If yes, specify type and estimated weekly value:_____ $_____

2. Was this employee promised work for any period of time? ☐ yes ☐ no, by whom? _____ For how long? _____
   If so, by whom? _____ If so, how long? _____

3. Was injured a steady, temporary or seasonal employee? (list one) _____
   If seasonal, how long will job last? _____

4. Estimated length of employment had injury not occurred? _____

5. Would rate of pay have changed had injury not occurred? ☐ yes ☐
   If yes, what would the new rate be? _____ When would rate be effective? _____/_____/_____

6. Are wages being continued? ☐ yes ☐ no. If no, date last paid _____/_____/_____
   If yes, is this considered: ☐ sick/vacation pay ☐ regular pay
   If regular pay, date next check is due _____/_____/_____ How long will salary be continued? _____
   Are you requesting reimbursement at employee's compensation rate? ☐ yes ☐ no

7. If employee is released to return to MODIFIED DUTY, is that available? ☐ yes ☐ no

Date: _____ Signed by: _____ (please print)

Signature: _____