Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006		

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.

Street Address or P.O. Box	City	State	Zip Code

Child Support Obligation: ❑ Current ❑ Past Due Payable to:

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name

Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

			Date /Time
Place of Accident	Date of Accident	Time of Accident	Employer Notified of Accident

What part of your body was injured? ____________________

Briefly discuss the cause of injury: ____________________

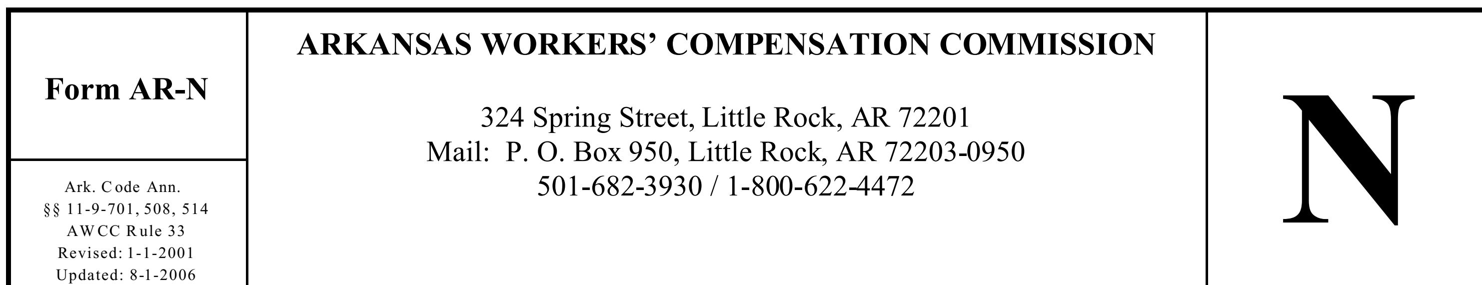
Name/address of witness(es): ____________________

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date____________________ Signature ____________________

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."



Form AR-N

Ark. Code Ann.
§§ 11-9-701, 508, 514
AWCC Rule 33
Revised: 1-1-2001
Updated: 8-1-2006

ARKANSAS WORKERS' COMPENSATION COMMISSION

324 Spring Street, Little Rock, AR 72201
Mail: P. O. Box 950, Little Rock, AR 72203-0950
501-682-3930 / 1-800-622-4472

N

EMPLOYER'S NOTICE TO EMPLOYEE

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]

Ark. Code Ann. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:
(A) If the employer had knowledge of the injury or death;
(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e). . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.

2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.

3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.

4. **If your employer has contracted with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.

5. **If your employer does not have a contract with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form

Formulario AR-N	**COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS**	**N**
Autoridad: Ark. Code Ann., apartado 11-9-702, 508, 514 AWCC Norma 33 Revisado: 1-1-2001 En Español: 10-15-2004 Actualizada: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

DATOS DEL EMPLEADO (utilizar tinta y mayúsculas)

Apellido	Nombre	Inicial del 2nd nombre	# de la Seguridad Soc.	Fecha de nacimiento	(Prefijo), número de teléfono particular

Dirección o apartado de correos	Ciudad	Estado	Código postal

¿Tiene obligacion de pagar manutencion de sus hijos? ❑ Estoy al corriente ❑ Estoy atrasado/a ❑ Pagaderos a:

DATOS DEL EMPLEADOR (utilizar mayúsculas)

Nombre del empleador (denominación con la que opera)	(Prefijo), número de teléfono del empleador

Dirección del empleador	Ciudad del empleador	Estado	Código postal

INFORMACIÓN SOBRE EL ACCIDENTE (utilizar mayúsculas)

			Día /Hora
Lugar del accidente	Fecha del accidente	Hora del accidente	Empleador informado del accidente

¿Qué parte del cuerpo se ha lesionado? ____________________

Describa brevemente las causas del accidente: ____________________

TESTIGOS

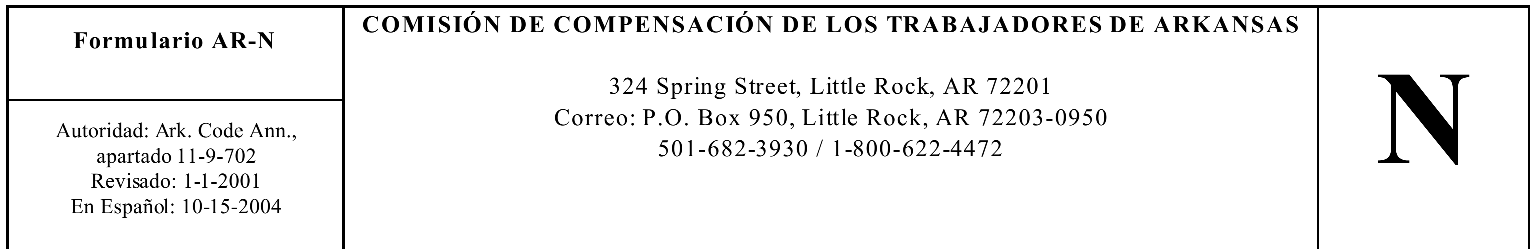
Nombre y dirección de los testigos, si procede: ____________________

Por la presente autorizo a cualquier hospital, médico, psicoterapeuta o profesional sanitario a suministrar al portador cualquier dato, oral o escrito, incluidos, entre otros, copias de los registros médicos relativos a mi estado físico, mental o emocional pasado, presente o futuro. Por la presente renuncio a mi privilegio médico (y psicoterapeuta o profesional sanitario)-paciente. Una copia fotostática de la presente autorización será tan válida como y efectiva como el original. Mi firma a continuación también indica que se me ha ofrecido el ejercicio de mis derechos relativos al cambio de médico. (Véase la información adicional al dorso.)

Fecha: ____________ Firma: ____________________

Puede obtenerse ayuda con respecto al formulario N de la AWCC de la División del Asesor Legal (1-800-520-2511 o 501-682-3930). Puede obtenerse información de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): "Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de prestaciones o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos íines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de losTrabajadores."



Formulario AR-N	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS 324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	N
Autoridad: Ark. Code Ann., apartado 11-9-702 Revisado: 1-1-2001 En Español: 10-15-2004		

NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

NOTIFICACIÓN AL EMPLEADO - Cumplimente este formulario para entregarlo a su empleador inmediatamente.

Ark. Code Ann., apartado 11-9-701. Notificación de fallecimiento o lesión.

(a) (1) A menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo, o si se comunica al empleador inmediatamente después de producirse, el empleado deberá informar del accidente a su empleador en una forma establecida o aprobada por la Comisión de Compensación de los trabajadores y a una persona y en un lugar especificado por el empleador, y el empleador no será responsable de las benefíciales de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente.

(2) Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación.

(3) Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

(b) (1) La falta de notificación no anulará las reclamaciones si:

(A) El empleador tiene conocimiento del fallecimiento o lesión; o

(B) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o

(C) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.

(2) Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

ELECCIÓN/CAMBIO DE MÉDICO

Derechos y responsabilidades. El tratamiento o los servicios suministrados o prescritos por un médico distinto del seleccionado de acuerdo con las siguientes disposiciones, excepto el tratamiento de urgencia, correrán a cargo del solicitante/empleado.

Ark. Code Ann., apartado 11-9-508. Servicios y suministros médicos.

"(e) ...[E]l empleado lesionado podrá tener acceso directo a cualquier proveedor de servicios oftalmológicos u optométricos que acepte suministrar servicios de acuerdo con las normas y condiciones relativas a los servicios prestados por la entidad de atención gestionada inicialmente elegida por el empleador para el tratamiento y control de lesiones o afecciones de los ojos."

1. Su empleador podrá seleccionar al médico de atención primaria inicial de entre los asociados con MCOs certificadas.

2. Podrá solicitar un cambio de médico. Inicialmente debería solicitar un cambio a la aseguradora o el empleador. En el plazo de cinco días laborables desde su solicitud inicial de cambio de médico, la aseguradora o el empleador deberían notificarle su decisión de concederle o denegarle el cambio de médico.

3. Si su solicitud de cambio de médico es denegada podrá enviar una petición al Secretario de la Comisión de Compensación de los trabajadores para un (1) único cambio de médico.

4. **Si su empleador tiene un contrato con una MCO certificada**, podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a la MCO certificada elegida por su empleador o que sea el médico que le atiende regularmente (Por "médico que le atiende regularmente" se entiende el facultativo que mantiene sus registros médicos y con el que cuente con un historial de tratamiento habitual anterior a la lesión para la que se puede solicitar la compensación"). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a la MCO certificada elegida por el empleador para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por la MCO certificada inicialmente elegida por su empleador.

5. **Si su empleador no tiene un contrato con una MCO certificada**, podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a una MCO certificada o que sea el médico que le atiende regularmente (véase la definición anterior). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a una MCO certificada para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por cualquier MCO certificada.

Dorso/ formulario a dos caras

Addendum to Workers Compensation and Employers Liability Insurance Policy Information Page

Fraud Statement

The following statement is requires by Arkansas code annotated 11-9-106; Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment or for the purpose of defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for either of said purposes, under this chapter shall be guilty of a Class D felony.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

OSHA LOG CASE #

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

INDUSTRY CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

M MALE

F FEMALE

U UNKNOWN

MARITAL STATUS

U UNMARRIED SINGLE/DIVORCED

M MARRIED

S SEPARATED

K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

( ) CANNOT BE DETERMINED

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

0 NO MEDICAL TREATMENT

1 MINOR: BY EMPLOYER

2 MINOR CLINIC/HOSP

3 EMERGENCY CARE

4 HOSPITALIZED > 24 HOURS

5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

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AWCC Form 1

(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversions including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.

2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.

3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.

4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): “Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers’ compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers’ Compensation Commission.”

(Revised 1-1-2001)

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

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EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

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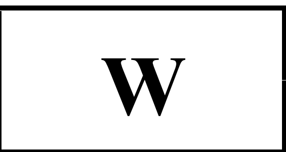
Form AR-W	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472
Authority: Ark. Code Ann. §11-9-518 Revised: 1-1-2001	



WAGE STATEMENT IMMEDIATELY PRECEDING INJURY DATE

Weeks	Straight Time Worked		Wages Paid For Straight Time	Overtime Hours Worked		Wages Paid for Overtine
	Days	Hours		Days	Hours	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
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43						
44						
45						
46						
47						
48						
49						
50						
51						
52						
Total						

AWCC No.

Carrier Claim No.

Employee Name:

Employee S.S.No.:

Employer Name:

Employer FEIN No.:

Carrier or Self-Insured Name:

Carrier NAIC No.:

INSTRUCTIONS FOR
COMPLETING WAGE STATEMENT
(To be completed only if claimant receives less than maximum benefits)

In completing the Wage Statement, in week one give information for the week prior to the injury and follow with preceding weeks. Days and hours of straight time work should be given in all cases.

Explanation of time lost by employee: ____________

____

____

____

____

____

W

AWCC Form W

(Wage Statement)

1. The **AWCC Advisory 88-1** requires respondents to file **Form W** (with the AWCC file number for the case, obtained from **AWCC Form A-110)** if the claimant receives less than the maximum compensation rate.

2. The average weekly wage of the injured worker shall "[I]n no case...be computed on less than a full-time workweek in the employment." **[Ark. Code Ann. § 11-9-518(a)(1)]**

Information on Form W is available from the Office Services Section. General Information is available from the Support Services Division. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106(a): “Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers’ compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers’ Compensation Commission.”