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

PO Box 20190, Cranston, RI 02920-0942

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

DWC No. _____

Insurer File No.

1. EMPLOYER LOCATION:	2. EMPLOYER NAMED ON WC INSURANCE POLICY: ☐ SAME AS BLOCK 1
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext. Type of Business	Phone Ext.
RI Unemployment Ins. No. NAICS	WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY:	4. CLAIM ADMINISTRATOR: ☐ SAME AS BLOCK 3
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.

5. EMPLOYEE INFORMATION:		6. MEDICAL INFORMATION:
SSN ☐ Male ☐ Female		Treatment Facility
Name		Address
Address		City, State, Zip
City, State, Zip		Phone Ext.
Phone	Date of Birth	7. WITNESS INFORMATION:
Occupation	Date Hired	Name Phone
State of Hire	Preferred Language of Employee: O English O Spanish O Portuguese O Other:	

8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐ AM ☐ PM	
Time employee began work ☐ AM ☐ PM	
1. First full day lost from work ☐ NONE LOST	
2. Date returned to work (if appropriate)	List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
3. Date employer notified of injury	
If fatal - REPORT WITHIN 48 HOURS - Date of death	

Place where injury/illness occurred: ☐ At employer location listed in Block 1 OR Complete address where accident occurred:

Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No

If Yes, date employer first notified of medical treatment or time lost

Category(ies) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown

Print Name of Report Preparer	Date Prepared	Phone & Extension
Print Name of Employer Contact Person OR ☐ Same as above		Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

For instructions visit our web site: www.dlt.ri.gov/wc

DLT Department of Labor and Training
RHODE ISLAND

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
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100

Claim Administrator File Number:

1. Employee information:		2. Claim information:	
SSN or ID Last four digits only	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 Exemptions ☐ Enter the maximum number of personal exemptions you are allowed to claim for workers' compensation purposes. 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

DWC-04 (Rev. 01/2021)

An Employee's Certificate of Dependency Status is required with a Memorandum of Agreement or a Nonprejudicial Agreement to verify marital status, maximum number of personal exemptions, and number of dependents for calculation of weekly benefits.

The claim administrator (the company handling the claim: the insurer, self-insured employer or third party administrator) completes sections 1 and 2 of the form. The employee completes the rest of the form, signs it, and returns the form to the claim administrator. The claim administrator sends the form to the DLT as part of a Nonprejudicial Agreement, Memorandum of Agreement, or as required by court order or decree.

Top of form:

- Correction Box: Check if this document is correcting a document previously filed.
- Claim Administrator File Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

1. Employee Information. The claim administrator completes section 1.
   - SSN: provide ***at most*** the last 4 digits of the employee's social security number or the employee ID number assigned by RIDLT. DO NOT USE A FICTITIOUS NUMBER. Please contact RI DLT to obtain an assigned employee ID number.
   - Name: enter the employee's first name, middle initial and last name.
   - Address: complete the employee's street address, city, state, and zip code.
   - Phone: provide the employee's phone number if available.
   - Date of Birth: enter the employee's date of birth if available.

2. Claim Information. The claim administrator completes section 2.
   - Employer name: enter the company name of the injured worker's employer.
   - Claim Administrator: enter the company name of the party handling the claim.
   - Address: complete the mailing address for the claim administrator.
   - Injury date: enter the injury date.
   - Incapacity date: Enter the incapacity date, which is the first full day that the employee was unable to work.

3. Marital Status. The employee completes section 3.
   - Check the **single** box if you are unmarried, widowed or divorced. Check the **married** box if you are married or separated.
   - If you are single, leave the rest of section 3 blank.
   - Check "Spouse works" if your spouse is employed or "Spouse does not work" if not. A non-working spouse qualifies as a dependent for workers' compensation.
   - Enter your spouse's name.

4. Number of Exemptions. The employee completes section 4.
   - Enter the maximum number of personal exemptions you are allowed to claim for workers' compensation purposes. This includes you, your spouse, your dependent children, and any other exemptions.
   - A single employee with no dependents has a maximum number of personal exemptions of at least one (1). A married employee with three (3) dependent children has a maximum number of personal exemptions of at least five (5); the employee, spouse and three children. An employee may be entitled to additional exemptions.

- The maximum number of allowed personal exemptions used here might not be the same number of personal exemptions or withholding allowances the employee actually claims for federal withholding.
- The Department of Labor and Training relies upon exemption guidelines established prior to the Tax Cuts and Jobs Act of 2017. You may refer to IRS Publication 501 (2017) for further guidance.

5. Dependents. The employee completes section 5.
   - Dependents for workers' compensation include children you support who are under age 18, full time students to age 23, or mentally or physically incapacitated from earning at any age.
   - A child may qualify as a personal exemption even if they do not qualify as a dependent for workers' compensation purposes. Contact your claim administrator if you believe that you are allowed to claim any other personal exemptions beside yourself, your spouse, and children who qualify as dependents for workers' compensation.

The employee must sign and date the form and return the form to the claim administrator.

RIDLT accepts any digital signature solutions that conform to current standards for integrity and authenticity. However, typed names in lieu of signatures do not meet this standard **and will not be accepted.**

The claim administrator sends the form to the Department of Labor and Training as part of a Nonprejudicial Agreement, Memorandum of Agreement, or as required by court order or decree.

Revised 01/2021

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 TTY (Relay RI): 711

DWC No. _____

Insurer File No. _____

EMPLOYEE INFORMATION:

SSN or ID (Last four digits only) XXX-XX-

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:

If Yes:		**OR:**	
1. List agreed upon hourly wage			
2. Number of hrs. per week for full-time employees		Give average weekly for same or similar employment:	
3. Multiply #1 by #2 for average weekly wage	$0.00		

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 worked. **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:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
Total number **usable** weeks:		Total earnings:	$0.00

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 13 weeks	$0.00
2. Total number usable weeks	0
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	**$0.00**
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	**$0.00**

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

State of Rhode Island
PART-TIME WAGE STATEMENT (Hired for less than 20 hours 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 TTY (Relay RI): 711

DWC No. _____

Insurer File No. _____

EMPLOYEE INFORMATION:

SSN or ID (Last four digits only) XXX-XX-

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:

If Yes:		**OR:**	
1. List agreed upon hourly wage			
2. Number of hrs. per week for part-time employees		Give average weekly for same or similar employment:	
3. Multiply #1 by #2 for average weekly wage	$0.00		

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:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
Total number usable weeks:		Total earnings:	$0.00

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 26 weeks	$0.00
2. Total number usable weeks	0
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	**$0.00**
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	**$0.00**

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

Wage Statement: Full-Time (DWC-03F) or Part-Time (DWC-03P)

Determine which Wage Statement to use:

- Full-time: use for employees hired for **20 hours or more** per week
- Part-time: use for employees hired for **less than 20 hours** per week
- Seasonal: use for employees hired for a **seasonal job** of 16 weeks or less

These instructions are for full-time or part-time employees. There are separate instructions for the seasonal wage statement. See the instructions for concurrent employment if the employee has more than one job.

The employer provides employee and wage information to the claim administrator: the insurer, self-insured employer or third party administrator handling the claim. The claim administrator completes the wage statement to calculate the employee's compensation rate. The wage statement is sent to Department of Labor and Training with the Memorandum of Agreement or Nonprejudicial Agreement.

Top of form:

Correction Box: Check if this document is correcting a document previously filed.
DWC No: For DLT use only. Please leave blank.
Insurer File Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

Employee Information.

SSN: provide ***at most*** the last 4 digits of the employee's social security number or the employee ID number assigned by RIDLT. DO NOT USE A FICTITIOUS NUMBER. Please contact RI DLT to obtain an assigned employee ID number.
Name: enter the employee's first name, middle initial and last name.
Hired for: Enter the number of hours the employee was hired to work each week. Check if the number of hours was approximate.
Supplemental wages? Check YES if these are wages from a supplemental employer (not the employer where the employee was injured) and give the supplemental employer's business name.
Maximum no. of exemptions: enter the maximum number of exemptions the employee may claim for tax purposes. Count the employee and his or her dependents and any other person who qualifies as an exemption for tax purposes. The number of exemptions must be at least one (the employee).
Check SINGLE if the employee is unmarried, widowed or divorced. Check MARRIED if the employee is married or separated.

Claim Information.

Employer: enter the business name of the injured worker's employer.
Insurance Co: give the name of the licensed insurer shown on the workers' compensation policy or the self-insured employer's name.
Claim Administrator: enter the name of the company handling the claim.
Injury date: Enter the date of the injury.

Incapacity date: Enter the first full calendar day that the employee was unable to work due to the injury.

Hire date: Enter the date the employee was hired (the first day the employee worked).

Employed less than 2 weeks: If the employee worked for less than two weeks before the injury, complete either the left or right section:

- Left section: wage times full-time (or part-time) hours
  1. List the agreed upon hourly **wage.**
  2. Enter the number of **hours** per week for the employer's full-time (or part-time) employees.
  3. Multiply wage (1.) times hours (2.) to give the average weekly wage.
- Right section: give the average weekly wage for employees with the same or similar jobs.

Employed more than 2 weeks:

- Determine the first week of wages to include.

Identify the incapacity date: the first full calendar day that the employee was unable to work due to the injury.

13 weeks of wages (26 weeks for part-time) before the **INCAPACITY DATE** should be included.

Start from the week of the INCAPACITY DATE (not the injury date) and work backward.

Did the employee work a full week for the week including the INCAPACITY date?

Yes, the employee worked a full week - use the week of the incapacity date as the first week of wages.

No, the employee did not work a full week - use the week before the incapacity date as the first week of wages, even if a full week was not worked that week.

- List 13 **CONSECUTIVE** weeks for full-time. List 26 **CONSECUTIVE** weeks for part-time.
  - Start with first week above. For Week Number 1, enter:
    - Week ending date.
    - Number of standard hours worked. If the employee worked more than 40 hours without overtime, note "NO OT" next to the hours worked so it is clear that overtime is not included.
    - Gross wages WITHOUT overtime. List gross pay without overtime and without bonuses. Overtime and bonus are calculated separately. INCLUDE these payments:
      - Commissions
      - Shift differential
      - Sunday pay
      - Paid holiday, sick and vacation
        - Include weeks the employee was not paid for plant shutdown or unpaid time off. Write "UNPAID" for Gross Wages and enter 0 (zero) in the Number of Standard Hours Worked.
  - Enter the week ending date, number of standard hours worked and gross wages for 13 CONSECUTIVE weeks for full-time (26 CONSECUTIVE weeks for part-time) before the incapacity. Do not skip any weeks. Include unpaid weeks as shown above.
  - Total number of **usable** weeks:
    - Count the number of weeks above where wages are listed. Do not count weeks

where Gross Wages are zero.
        - Fill in the number of usable weeks.
    - Total earnings: add all the gross wages and enter the total.
- Bonus and Overtime Calculation
    - Average Bonus:
        - Number of weeks employed (up to 52). Fill in the number of weeks the worker has been employed up to 52. If employed less than 52 weeks, use the actual number of weeks employed. If employed more than 52 weeks, use 52.
        - Total bonus amount paid in the past 52 weeks. Fill in the total amount of bonuses paid to the employee in the last 52 weeks.
        - Average bonus: divide Total Bonus (block 2) by Number of Weeks (block 1) to get the average bonus.
    - Average Overtime:
        - Total Overtime: enter the total amount of overtime paid in the last 52 weeks in block 4.
        - Average: divide Total Overtime (block 4) by Number of Weeks (block 1) to get the average overtime. Enter it in block 5.
- Calculate Average Weekly Wage (AWW)

1. Total Earnings: Enter the total earnings from the end of the section listing 13 (full-time) or 26 (part-time) consecutive weeks of wages.
2. Usable Weeks: Enter the total number of usable weeks from the end of the section listing 13 (full-time) or 26 (part-time) consecutive weeks of wages.
3. AWW no Bonus no OT: Divide total earnings (1.) by total number of usable weeks (2.) and enter the result. This is average weekly wage without bonus and without overtime.
4. Average bonus: enter the average bonus from Block 3 in the Bonus and Overtime section above.
5. Average weekly wage excluding overtime (AWW no OT): add (3.) AWW no Bonus no OT) and (4. Average Bonus).
6. Average overtime: enter the average overtime from Block 5 in the Bonus and Overtime section above.
7. Add (5.) and (6.) to Total Average Weekly Wage.

Preparer and Adjuster.

- Print Preparer Name and Date: Print the name of the person who filled out the form and enter the date the form was prepared.
- Printer Adjuster Name and Date: Print the name of the adjuster who checked the form and the date the form was completed.

Revised 01/2021

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 TTY (Relay RI): 711

DWC No. _____

Insurer File No. _____

EMPLOYEE INFORMATION:

SSN or ID (Last four digits only) XXX-XX-

Name

Maximum no. of exemptions ☐ ☑ Single ☑ Married

Wages for how many employers are listed below ☐

Do not use shaded areas below:

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:	0.00		Total earnings:	0.00

1. Combine total earnings listed $0.00
2. Divide total earnings by 52 ÷ 52
3. Average Weekly Wage $0.00

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

For completion instructions visit our web site: www.dlt.ri.gov/wc

Wage Statement: Seasonal (DWC-03S)

Determine which Wage Statement to use:

- Full-time: use for employees hired for **20 hours or more** per week
- Part-time: use for employees hired for **less than 20 hours** per week
- Seasonal: use for employees hired for a **seasonal job** of 16 weeks or less

These instructions are for seasonal employees. There are separate instructions for full-time and part-time employee wage statements. See the instructions for concurrent employment if the employee has more than one job.

The employer provides employee and wage information to the claim administrator: the insurer, self-insured employer or third party administrator handling the claim. The claim administrator completes the wage statement to calculate the employee's compensation rate. The wage statement is sent to Department of Labor and Training with the Memorandum of Agreement or Nonprejudicial Agreement.

Top of form:

Correction Box: Check if this document is correcting a document previously filed.
DWC No: For DLT use only. Please leave blank.
Insurer File Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

Employee Information.

SSN: provide ***at most*** the last 4 digits of the employee's social security number or the employee ID number assigned by RIDLT. DO NOT USE A FICTITIOUS NUMBER. Please contact RI DLT to obtain an assigned employee ID number.
Name: enter the employee's first name, middle initial and last name.
Maximum no. of exemptions: enter the maximum number of exemptions the employee may claim for tax purposes. Count the employee and his or her dependents and any other person who qualifies as an exemption for tax purposes. The number of exemptions must be at least one (the employee). Check SINGLE if the employee is unmarried, widowed or divorced. Check MARRIED if the employee is married or separated.
How many employers? Enter the total number of employers that paid the employee in the last 52 weeks and have wages included below.

Claim Information.

Employer: enter the company name of the employer where the employee was injured.
Insurance Co: give the name of the licensed insurer shown on the workers' compensation policy or the self-insured employer's name.
Claim Administrator: enter the name of the company handling the claim.
Injury date: Enter the date of the injury.
Incapacity date: Enter the first full calendar day that the employee was unable to work due to the injury.
Hire date: Enter the date the employee was hired (the first day the employee worked).

Wage information.

- Determine the first week of wages to include.

Identify the incapacity date: the first full calendar day that the employee was unable to work due to the injury.
Include 52 weeks of wages before the incapacity date **from all employers**.

- List 52 **CONSECUTIVE** weeks of gross wages from all employers working backwards from the incapacity date.
  - For each week, enter:
    - Week ending date.
    - Gross wages. Include overtime, bonus, commissions, shift differential, and paid time off.
  - Enter zero as gross wages for any week in the prior 52 weeks where the employee had no earnings.
  - Total earnings:
    - Add the gross wages and enter the total for each column.
    - Add the two column totals and enter in #1 Combine Total Earnings
  - Average Weekly Wage:
    - Divide the combined total earnings by 52 weeks. Always divide by 52 weeks even if earnings were zero for some weeks.
    - Enter the result, the average weekly wage, in #3.

Preparer and Adjuster.

- Print Preparer Name and Date: Print the name of the person who filled out the form and enter the date the form was prepared.
- Printer Adjuster Name and Date: Print the name of the adjuster who checked the form and the date the form was completed.

Revised 01/2021

Wage Statement: Multiple Employers

RIGL § 28-33-20 established the rules to calculate earnings for average weekly wage.
This document provides direction on how to determine the average weekly wage when the injured worker has more than one employer. The job where the employee was injured is the primary employment. Any additional jobs are concurrent employment. Indicate the primary employer and concurrent employer on the wage statement.

1. More than one full-time job:
   a. Gather from each employer:
      i. Date of hire. If the employee was hired less than a year before the injury, date of hire is required to figure the number of weeks employed up to 52.
      ii. 13 weeks of wages prior to the date of incapacity
      iii. Amount of bonus paid in the last 52 weeks
      iv. Amount of overtime paid in the last 52 weeks
   b. Calculate Total Average Earnings (also known as Average Weekly Wage No Bonus No Overtime) for all employers.
      i. Add 13 weeks of wages from all employers together to get Total Earnings.
      ii. Divide Total Earnings by the highest number of usable weeks for any employer. This gives the Average Earnings.
   c. Calculate Total Average Bonus.
      i. Divide the amount of bonus paid for each job by the number of weeks employed at that job to get Average Bonus for each job. Use the date of hire to determine number of weeks employed at that job up to a maximum of 52 weeks.
      ii. Add the Average Bonuses for each job together to get Total Average Bonus for all jobs.
   d. Calculate Average Weekly Wage with Bonus No Overtime.
      i. Add Total Average Earnings to Total Average Bonus to get Average Weekly Wage with Bonus No Overtime.
      ii. The Average Weekly Wage with Bonus No Overtime figure is important. It is the threshold to determine if the employee's post-injury earnings have recovered to pre-injury levels and benefits may be discontinued.
   e. Calculate Total Average Overtime.
      i. Divide the amount of overtime paid for each job by the number of weeks employed at that job to get Average Overtime for each job. Use the date of hire to determine number of weeks employed at that job up to a maximum of 52 weeks.
      ii. Add the Average Overtime for each job together to get Total Average Overtime for all jobs.
   f. Calculate Total Average Weekly Wage with Bonus and Overtime.
      i. Add Total Average Weekly Wage with Bonus No Overtime and Total Average Overtime to get Total Average Weekly Wage With Bonus And Overtime.
      ii. This is the figure used to calculate the compensation rate.

2. More than one part-time job.
   a. Calculated the same as more than one full-time job, but use up to 26 weeks of wages prior to the date of incapacity instead for 13 weeks.

3. More than one seasonal job.
   a. Include the employee's earnings from all employers for the 52 weeks before the date of incapacity.
   b. Bonus and overtime are included.
   c. Include weeks where earnings were zero.
   d. Divide

4. Injured at full-time job and also has a part-time job:
   a. Calculated the same as more than one full-time job.
   b. Use 13 weeks of wages from the full-time employer.
   c. Use 13 weeks (not 26) of wages from the part-time employer.

5. Injured at part-time job and also has a full-time job:
   a. Use 26 weeks of wages from the part-time employer. Complete the entire wage statement to calculate Average Weekly Wage with Bonus and Overtime for the part-time primary employer.
   b. Use 13 weeks of wages from the full-time employer. Complete the entire wage statement to calculate Average Weekly Wage with Bonus and Overtime for the full-time concurrent employer.
   c. Add the Average Weekly Wage With Bonus And Overtime from both employers together.

6. Full-time and seasonal job, injured at either:
   a. Use 52 weeks of wages including bonus and overtime from seasonal employer(s). Complete the entire wage statement to calculate Average Weekly Wage.
   b. Use 13 weeks of wages from the full-time employer. Complete the entire wage statement to calculate Average Weekly Wage with Bonus and Overtime for the full-time employer.
   c. Add the seasonal Average Weekly Wage to the full-time Average Weekly Wage With Bonus And Overtime together.

7. Part-time and seasonal job:
   a. Use 52 weeks of wages including bonus and overtime from seasonal employer(s). Complete the entire wage statement to calculate Average Weekly Wage.
   b. Use 26 weeks of wages from the full-time employer. Complete the entire wage statement to calculate Average Weekly Wage with Bonus And Overtime for the part-time employer.
   c. Add the seasonal Average Weekly Wage to the part-time Average Weekly Wage With Bonus And Overtime together.

Revised 01/2021

State of Rhode Island
REPORT OF EARNINGS
Department of Labor and Training, Division of Workers' Compensation
Phone: (401) 462-8100 Fax: (401) 462-8105 TTY (Relay RI): 711

DLT Department of Labor and Training RHODE ISLAND

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN or ID Last four digits only XXX-XX-
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:	Date Earned:	Amount:	Date Earned:	Amount:	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: _____

The claim administrator (the company handling the claim: the insurer, self-insured employer or third party administrator) sends the form to the employee to complete at the beginning of a claim, at reasonable intervals throughout the claim, and at the end of a claim. The employee completes the form and **returns it to the claim administrator.**

Top of form:

- Insurer File Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

1. Employee Information. The claim administrator completes section 1.
   - SSN: enter ***at most*** the last 4 digits of the employee's social security number or the employee ID number assigned by DLT. DO NOT use a fictitious number.
   - Name: enter the employee's first name, middle initial and last name.
   - Address: complete the employee's street address, city, state and zip code.
   - Provide the employee's phone number if available.

2. Claim Administrator Information. The claim administrator completes section 2.
   - Complete the information for the company handling the claim. Provide the claim administrator business name, mailing address, and phone number.
   - Reporting period. From date: enter the first day the employee lost time from work due to the injury (incapacity date).

3. Notice to Employees Receiving Workers' Compensation: Employee should read the complete notice.

4. Employee Complete:
   - Read the questions and WRITE IN either YES or NO.
   - If you answered NO to BOTH questions, sign and date the form. Return the completed form to the **claim administrator** (not to RI Department of Labor and Training).
   - If you answered YES to either question, complete the employer and earnings information.
   - Employer information: give the business name and address of the employer that provided the earnings.

5. The employee reports earnings received: give the date of earnings and amount received. Attach another page if needed.

Signature:

- The employee must sign and date the form.
- A witness to the employee's signature must sign and date the form.

RIDLT accepts any digital signature solutions that conform to current standards for integrity and authenticity. However, typed names in lieu of signatures do not meet this standard **and will not be accepted.**

Return the form to the **CLAIM ADMINISTRATOR**, not to the Department of Labor & Training.