

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.
Nashville, Tennessee 37243-1002



WAGE STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

Employee: _____ SSN: _____ State File # _____

Insurer Claim #: _____ Date of Injury _____

In order to determine the correct rate of compensation to be paid to the above injured party, please fill in the schedule below and return it promptly. This information is required by law and no agreement for payment of compensation can be made until it has been received. Please complete 52 weeks prior to date of accident.

Please describe allowances of any character made in lieu of wages that must be deemed a part of employee's earnings: _____

If the average weekly wage is not based on fifty-two weeks of earnings proceeding the date of injury, please show your computation below: _____

WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES	WEEK	NO. DAYS	WEEK ENDING	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 PAID								

Rate per Day _____ Rate per Hour _____ Average per Week _____

I hereby certify that the above is a true and correct account, as taken from our time books or payroll records, of the wages paid to the above-named injured employee for the periods indicated.

Date _____ 20____ Employer _____

Name of Preparer & Title _____

Phone, Fax, Email _____