



Instructions: The employer should complete and sign this Wage Statement unless the injured worker is self-employed or unemployed. If the injured worker is self-employed or unemployed, both the Wage Statement and the affidavit must be completed.

Failure to file wage statements may delay or stop compensation.

The affidavit below may be sworn to without cost before a deputy in a BWC local customer service office.

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by the BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Form with fields: Date of injury, Claim number, Injured worker's name, Employer name, Telephone number

If you are applying for wage loss benefits, please include from and to dates.

Form with fields: From, To

If employee was employed continuously and/or seven days prior to date of injury - answer 1 & 2. If employed less than seven days prior to date of injury - answer 3 & 4.

Summary table with 4 columns: 1. Total gross wages for six weeks prior to injury, include overtime; 2. Gross wages (excluding overtime) for seven days prior to injury; 3. Employee's hourly rate of pay the week injury occurred; 4. Number of hours employee was scheduled to work, week of injury

Use the worksheet below to report the employee's weekly wage for the year immediately prior to the date of injury, or attach a report which contains the required information. Use total gross earnings. Make no deductions for Social Security, pensions, insurance, unemployment, etc. BWC must have an entire year to compute the rate of compensation. If the employee did not work during any period, state reason(s) below--(Personal, plant shutdown, other injury, illness, etc.)

Table with 9 columns: Pay period ending, Amount earned, # of Days worked, For pay period ending, Amount earned, # of days worked, For pay period ending, Amount earned, # of Days worked. Includes a section for self-insuring use only with FWW and AWW fields.

If employee received meals, lodging, tips, etc. in addition to wages, describe and state weekly value.

Will employee receive any wages, meals, lodging, health and accident insurance benefits or any other employee benefits during period of disability which are fully paid for by the employer? . . . Yes No If yes, indicate period(s) and amount(s).

I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

X _____ Employer signature and title

Affidavit

State of Ohio, County of _____ SS: _____ being first duly sworn, says that the entire earnings from _____ to _____ ; as listed above is correct.

If unable to write, mark must be witnessed by two persons.

Signature of applicant

Sworn to before me, and subscribed in my presence _____ day of _____ .

Official title