



P.O. Box 32036, Lakeland, FL 33802-2036

### EMPLOYERS® WAGE REPORT

It is necessary for us to determine the average weekly earnings of your employee named below who was injured in an accident while in your employment. Please complete and return the wage report below, which is required by your state's workers' compensation law.

Please fill in all the wages paid to the employee during the three (3) months before the accident, showing the number of days on which any work was done during each week, including part-time days. If the injured worker was not paid on a weekly basis, explain fully and give the earnings during the 13 weeks preceding the accident.

Employee	Claim Number:
Injury Date:	Wage Rate:
Disability Date:	Date Employed:

Week No.	Date From	Date To	Total Hours	Hourly Rate	Days Worked	Gross Pay Including Overtime
1					\$	\$
2					\$	\$
3					\$	\$
4					\$	\$
5					\$	\$
6					\$	\$
7					\$	\$
8					\$	\$
9					\$	\$
10					\$	\$
11					\$	\$
12					\$	\$
13					\$	\$

<b>Totals</b>				
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What number of hours was a normal work day? \_\_\_\_\_

What number of days was a normal work week? \_\_\_\_\_

Did the employee receive any premium, bonus, board or lodging from you in addition to the wages listed above?

\_\_\_\_\_  
\_\_\_\_\_

If so, please explain, stating amounts of value thereof \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Did the employee do the same type of work during all of the time while employed by you during the year before the accident?

\_\_\_\_\_  
\_\_\_\_\_

If not, please explain fully: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Once completed, please fax to EMPLOYERS at 800-371-8204.**

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