

Suspension Agreement and Receipt

State of Rhode Island
Department of Labor and Training
Division of Workers' Compensation
P.O. Box 20190
Cranston, RI 02920-0942
Phone: (401) 462-8100 TDD: (401) 462-8084

DWC No: _____

Insurer's No: _____

EMPLOYEE INFORMATION:

S.S.N. _____ M ___ F
Name _____
Address _____
City, State, Zip _____
Phone _____ Date of birth _____

EMPLOYER INFORMATION:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

INSURANCE CARRIER:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

ADJUSTING COMPANY:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

INJURY INFORMATION:

Date of injury _____

Date of incapacity _____

We agree that weekly compensation benefits which began on _____(date) shall be stopped as of _____(date). Payment of medical bills related to this injury may continue. This is not a settlement of this case and does not prevent the employee from claiming future weekly compensation benefits in the event that the employee is unable to work due to this injury.

Employee Signature

Date

Employer/Insurer Signature

Date