

# Wage Transcript

**This form will not be accepted for filing unless all information is completed.**

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:

Soc. Sec. No. \_\_\_\_\_ M \_\_\_ F  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Date of birth \_\_\_\_\_

## CLAIM INFORMATION:

Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Adjusting Co. \_\_\_\_\_  
Injury date \_\_\_\_\_  
Incapacity date \_\_\_\_\_

## INSURER COMPLETE:

This wage transcript is submitted to support a:

- Discontinuation of benefits. The employee has returned to work at a wage equal or greater than he/she earned at the time of the injury.
- Reduction of benefits. The employee has return to work at a wage less than he/she earned at the time of the injury.

Date benefits were discontinued or reduced: \_\_\_\_\_

Pre-injury average weekly wage, not including overtime: \_\_\_\_\_

## EMPLOYER COMPLETE: (Weeks must be consecutive)

Post – Injury Earning Information					
	Period Start Date	Period End Date	No. Hours Worked	Payment Rate	Amount of Earnings
Week 1					
Week 2					

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Employer's Treasurer

\_\_\_\_\_  
Date

Please return this completed form to insurer or adjuster handling the claim.

The employee has two (2) weeks to file an objection with the Department of Labor and Training.