WAGE STATEMENT

FOR CARRIER'S DATE STAMP
REC'D BY CARRIER

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY
DIVISION OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or insurance carrier. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	DATE OF ACCIDENT (mm/dd/yyyy)
EMPLOYER NAME & ADDRESS: Street: _____ City: _____ State: _____ Zip: _____	CONCURRENT EMPLOYER NAME & ADDRESS (If applicable): Street: _____ City: _____ State: _____ Zip: _____	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? YES NO SIMILAR EMPLOYEE'S NAME:
TELEPHONE	TELEPHONE	SSN OF SIMILAR EMPLOYEE

EMPLOYEE'S CUSTOMARY WORK WEEK:	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK:	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK:	OCCUPATION OF SIMILAR EMPLOYEE
(ex. Saturday thru Friday – Use 7 calendar day period)	(ex. 5 days / week)	(ex. 40 hours / week)	

NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your carrier within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your carrier within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

Please list wages earned for the 91 day period immediately preceding the accident.
DO NOT combine wages of two or more employees.

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) **EMPLOYER COST ONLY** HEALTH INSURANCE	RENT/ HOUSING
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
TOTAL								

RETURN THIS FORM TO:
(Carrier Name, Address & Telephone#)

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?	
YES NO	YES NO
TOTAL FRINGE BENEFITS	$
TOTAL OF GROSS PAY, GRATUITIES AND FRINGES	$
(FOR CARRIER USE ONLY) **AWW**	**COMP RATE**

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information, is guilty of a felony of the third degree.

PREPARER'S NAME	TELEPHONE	**DATE** (mm/dd/yyyy)