

# Wage Statement

Employer:	Date Prepared:	Injured Employee's Name:
Injured Employee's SSN:	Date of Injury:	IWIF Claim Number:

Please list the employee's **weekly gross earnings** for each of the **14 weeks immediately prior to the date / week of the accident.**

Week Number	Week Ending Month / Day / Year	Gross Salary (Include all overtime)	Additional Income (if applicable)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

If this claimant was given free rent, lodging, board, tips, or other allowances in addition to the above gross salary, please write the weekly value of that in the "**Additional Income**" column.

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Date

**Please return this form to your claims representative via fax at 410-494-2122.** Please call your IWIF claims representative if you have any questions. Thank you very much for your time.