# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## WAGE STATEMENT

| Board Claim No. | Employee Last Name | Employee First Name | M.I. | Date of Injury |
|---|---|---|---|---|
| | | | | |

## A. IDENTIFYING INFORMATION

| | | | | |
|---|---|---|---|---|
| **EMPLOYEE** | | Mailing Address | | |
| E-mail Address | | City | State | Zip Code |
| **EMPLOYER** | Name | Mailing Address | | |
| E-mail Address | | City | State | Zip Code |
| **INSURER/ SELF-INSURER** | Name | | | |
| **CLAIMS OFFICE** | Name | Mailing Address | | |
| SBWC ID # | Insurer/Self-Insurer File # | City | State | Zip Code |

## B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

❑ 13 Weeks of Employee's Wages ❑ 13 Weeks of a Similar Employee's Wages ❑ Full Time Weekly Wage of Injured Employee: $_____

### SCHEDULE OF WEEKLY EARNINGS

| Week | From Date MM/DD/YYYY | To Date MM/DD/YYYY | No. of Days Worked | Gross Amount Paid Including Overtime or Extra Work | Value of Additional Compensation | | | | | Total Earnings |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Meals | Lodging | Rent | Tips | Other | |
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |
| 11 | | | | | | | | | | |
| 12 | | | | | | | | | | |
| 13 | | | | | | | | | | |
| | | | **Total** | | | | | | | |
| | | | **Average Weekly Earnings** | | | | | | | |

## C. SCHEDULED DAYS OFF

**REQUIRED TO COMPLETE:** ❑ Mon ❑ Tue ❑ Wed ❑ Thur ❑ Fri ❑ Sat ❑ Sun ❑ No Off Days

## D. REMARKS

REMARKS:

| Type or Print Name | Signature | Date |
|---|---|---|
| | | |
| E-mail Address | | Phone Number |
| | | |

**IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov**

**WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).**