WAGE STATEMENT

INSTRUCTIONS: This Wage Statement should be completed and signed by the employer unless the injured worker is self-employed or unemployed. If the injured worker is self-employed or unemployed, both the Wage Statement and the affidavit must be completed.
FAILURE TO FILE WAGE STATEMENTS MAY DELAY OR STOP COMPENSATION.

The affidavit below may be sworn to without cost before a deputy in a local customer service office of the Bureau of Workers' Compensation.

Date of injury	Claim number
Injured Worker's name	
Employer name	Telephone number

52 WEEKS PRIOR TO, **BUT NOT INCLUDING,**
THE WEEK OF THE DATE OF INJURY

If you are applying for Wage Loss benefits, please include FROM and TO dates.

FROM	TO

If employee was employed continuously and/or 7 days prior to date of injury – answer 1 & 2. If employed less than 7 days prior to date of injury – answer 3 & 4.

1. Total gross wages for 6 weeks prior to injury, INCLUDE overtime	2. Gross Wages (excluding overtime) for 7 days prior to injury (using last pay period prior to date of injury)	3. Employee's hourly rate of pay the week injury occurred	4. Number of hours employee was scheduled to work, week of injury

The following worksheet is used to report the employee's WEEKLY WAGE for the year immediately prior to the date of injury or attach a report which contains the required information. Use total **gross** earnings. Make no deductions for social security, pensions, insurance, unemployment, etc. BWC must have an entire year to compute the rate of compensation. If the employee did not work during any period, state reason(s) below–(Personal, plant shutdown, other injury, illness, etc.)

Pay Period Ending	Amount Earned	# of Days Worked	For Week Ending	Amount Earned	# of Days Worked	For Week Ending	Amount Earned	# of Days Worked
						FOR SELF-INSURING USE ONLY		
						FWW	AWW	

If employee received meals, lodging, tips, etc. in addition to wages, DESCRIBE AND STATE WEEKLY VALUE.

Will employee receive any wages, meals, lodging, health and accident insurance benefits or any other employee benefits during period of disability which are fully paid for by the employer? . . . ☐ Yes ☐ No If yes, indicate period(s) and amount(s).

X____
Employer signature and title

AFFIDAVIT

STATE OF OHIO COUNTY OF____________________ ss: _________________________________ being first duly sworn, says that the entire earnings from __________________to ________________ _____; as listed above is correct.

If unable to write, mark must be witnessed by two persons.

____
Signature of applicant

Sworn to before me, and subscribed in my presence ______ day of _________________________________ ________

____

____
Official title

BWC-1217 (Rev. 1/20/2004)
C-94-A