

**FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY  
DIVISION OF WORKERS' COMPENSATION  
1-800-342-1741 (or) contact your local office for assistance**

FOR CARRIER'S DATE STAMP	
REC'D BY CARRIER	SENT TO DIVISION

## WAGE STATEMENT

EMPLOYEE NAME & ADDRESS:	EMPLOYER NAME & ADDRESS:	SOCIAL SECURITY #
TELEPHONE:	TELEPHONE:	DATE OF ACCIDENT

SALARY/WAGES (Paid by Employer)						GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (Employee Received)		
Check if Similar Employee Used <input type="checkbox"/>							FOR ALL DATES OF ACCIDENT		FOR DATES OF ACCIDENT PRIOR TO 7/1/90
WEEK NO.	WEEK		NO. OF DAYS WORKED	NO. OF HOURS WORKED	GROSS PAY	HEALTH INSURANCE	RENT/HOUSING	OTHER	
	FROM	TO							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
TOTAL						WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?			
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						TOTAL FRINGE BENEFITS		\$	
EMPLOYER SIGNATURE _____					DATE _____	TOTAL OF WAGES, GRATUITIES AND FRINGES		\$	

**NOTICE TO EMPLOYER:** If you discontinue any fringe benefit which you have elected to continue providing as noted above, you must notify the Carrier in writing of the last date the fringe benefit was provided and specify the type.

### CARRIER INFORMATION

Did the average weekly wage and compensation rate need adjusting based on the information provided above? <input type="checkbox"/> Yes <input type="checkbox"/> No		Carrier File # _____
Initial Average Weekly Wage	\$ _____	Initial Compensation Rate
Adjusted Average Weekly Wage	\$ _____	Adjusted Compensation Rate
Amount of Underpayment	\$ _____	Date Adjusted Amount Paid to Employee
Amount of Overpayment	\$ _____	Recouped at \$ _____ / wk. for _____ wks.
ADJUSTER NAME:	CARRIER NAME, ADDRESS & TELEPHONE:	
ADJUSTER SIGNATURE:	DATE: ____ / ____ / ____	

**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.**