Form AWW-CON
Average Weekly Wage Certification-Concurrent
October 2016 Edition

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

CLAIM NO. ____________________

____________________ **PLAINTIFF/EMPLOYEE**

VS **WAGE CERTIFICATION**

____________________ **DEFENDANT/EMPLOYER**

1. Date of Injury/Exposure as reported on Claim Form ____________________

2. Method of Wage Payment (check one):

☐ Hourly Amount ____________ ☐ Daily Amount ____________

☐ Weekly Salary Amount ____________ ☐ Monthly Salary Amount ____________

☐ Yearly Salary Amount ____________ ☐ Output of Employee Amount ____________

3. Date of Hire or Employment: ____________________

4. Name of concurrent employer: ____________________

5. Did Employer provide any of the following (check appropriate ones):

☐ Board ☐ Rent ☐ Housing

☐ Lodging ☐ Fuel

6. Did Employee (check appropriate ones):

☐ Work Overtime ☐ Receive Gratuities ☐ Paid Vacation/Holidays

Plaintiff/Employee's Name: ______________________________

Claim Number: ______________________________

	Weeks Worked Month/Day/Year	Total Regular and Overtime Hours Worked		Regular Hourly Rate		
1.			X		=	
2.			X		=	
3.			X		=	
4.			X		=	
5.			X		=	
6.			X		=	
7.			X		=	
8.			X		=	
9.			X		=	
10.			X		=	
11.			X		=	
12.			X		=	
13.			X		=	

Total: $ ______________

÷ by 13 weeks = $ ______________

14.			X		=	
15.			X		=	
16.			X		=	
17.			X		=	
18.			X		=	
19.			X		=	
20.			X		=	
21.			X		=	
22.			X		=	
23.			X		=	
24.			X		=	
25.			X		=	
26.			X		=	

Total: $ ______________

÷ by 13 weeks = $ ______________

	Weeks Worked Month/Day/Year	Total Regular and Overtime Hours Worked		Regular Hourly Rate		
27.			X		=	
28.			X		=	
29.			X		=	
30.			X		=	
31.			X		=	
32.			X		=	
33.			X		=	
34.			X		=	
35.			X		=	
36.			X		=	
37.			X		=	
38.			X		=	
39.			X		=	

Total: $ ____________

÷ by 13 weeks = $ ____________

40.			X		=	
41.			X		=	
42.			X		=	
43.			X		=	
44.			X		=	
45.			X		=	
46.			X		=	
47.			X		=	
48.			X		=	
49.			X		=	
50.			X		=	
51.			X		=	
52.			X		=	

Total: $ ____________

÷ by 13 weeks = $ ____________

CERTIFICATION

I certify that the above wage information is a true and accurate accounting of my wages from the concurrent employer(s) identified above for the fifty-two (52) weeks prior to the date of injury or last exposure set forth in the Claim form.

____

Plaintiff/Employee

____

Signature

____

Date

CERTIFICATE OF SERVICE

Unless this form has been submitted electronically, I certify that the original of this wage certification was mailed this ____________ day of ___________________ , 20 _____ to the Commissioner and a copy of the same to Counsel of record and the assigned Administrative Law Judge.

____

Attorney for the Plaintiff/Employee or Plaintiff/Employee