

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):

- | | |
|---|--|
| <input type="checkbox"/> Hourly Amount _____ | <input type="checkbox"/> Daily Amount _____ |
| <input type="checkbox"/> Weekly Salary Amount _____ | <input type="checkbox"/> Monthly Salary Amount _____ |
| <input type="checkbox"/> Yearly Salary Amount _____ | <input type="checkbox"/> Output of Employee Amount _____ |

3. Date of Return to Work: _____

4. Place of Return to Work: _____

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

- | | | |
|----------------------------------|-------------------------------|----------------------------------|
| <input type="checkbox"/> Board | <input type="checkbox"/> Rent | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Lodging | <input type="checkbox"/> Fuel | |

6. Did Employee (check appropriate ones):

- | | | |
|--|---|---|
| <input type="checkbox"/> Work Overtime | <input type="checkbox"/> Receive Gratuities | <input type="checkbox"/> 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 the wages of _____ Subsequent to the date of the injury/last exposure set forth in the claim form.
Plaintiff/Employee

Name of Company

Signature

Title

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