

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
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### A. IDENTIFYING INFORMATION

<b>EMPLOYEE</b>	County of Injury	Address			
E-mail Address		City	State	Zip Code	
<b>EMPLOYER</b>	Name	Address			
E-mail Address		City	State	Zip Code	
<b>INSURER/ SELF-INSURER</b>	Name	SBWC ID# (five digit number)			
<b>CLAIMS OFFICE</b>	Name	Claims Office Address			
E-mail Address		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.

<input type="checkbox"/> 13 Weeks of Employee's Wages	<input type="checkbox"/> 13 Weeks of a Similar Employee's Wages	<input type="checkbox"/> Full time weekly wage of injured employees	Wage at date of injury per week:
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### 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										
<b>Total</b>										
<b>Average Weekly Earnings</b>										

<b>C.</b>	REMARKS:	REQUIRED TO COMPLETE:	OFF DAYS	<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thur	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
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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.sbcw.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).