

**STATEMENT OF DAYS WORKED AND EARNINGS OF
INJURED EMPLOYEE**

IC File # _____
 Emp. Code # _____
 Carrier Code # _____
 Carrier File # _____
 Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____	Employer's Name _____ Telephone Number _____
Address _____	Employer's Address _____ City _____ State _____ Zip _____
City _____ State _____ Zip _____	Insurance Carrier _____ Policy Number _____
Home Telephone _____ Work Telephone _____	Carrier's Address _____ City _____ State _____ Zip _____
Social Security Number _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth _____	Carrier's Telephone Number _____ Fax Number _____

Year:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned		
Jan.																																		
Feb.																																		
Mar.																																		
Apr.																																		
May																																		
June																																		
July																																		
Aug.																																		
Sept.																																		
Oct.																																		
Nov.																																		
Dec.																																		
Total																																		

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: \$ _____

MAIL TO:
 NCIC - CLAIMS SECTION
 4335 MAIL SERVICE CENTER
 RALEIGH, NORTH CAROLINA 27699-4335
 MAIN TELEPHONE: (919) 807-2500
 OMBUDSMAN: (800) 688-8349

The undersigned employer of _____
(Name of Employee)
who alleges an injury on the _____ of _____
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

Employer
By _____
Authorized Signature

Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated- It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

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