1. REVISION DATE:	**WAGE STATEMENT**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PART(S) AFFECTED:	

EMPLOYER/INSURER

15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:
18. INSURER NAME:	19.INSURER MAILING ADDRESS AND PHONE NUMBER:	

NOTICE TO EMPLOYEE

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

20. Does employee work concurrently? ☐ Yes ☐ No If yes, a Wage Statement must be submitted for each employer.

Names: (1) _____ (2)_____ (3)_____

21. Method of Calculation:

☐ 102(4)(A) – Salaried ☐ 102(4)(C) – Seasonal Worker

☐ 102(4)(B) – Varying Wages ☐ 102(4)(D) – Other*

* You must submit a minimum of 2 comparable Wage Statements with this filing and provide a detailed explanation of the calculation.

22. LIST GROSS EARNINGS FOR EACH WEEK:

WK 1	WEEK ENDING	GROSS EARNINGS	WK 19	WEEK ENDING	GROSS EARNINGS	WK 37	WEEK ENDING	GROSS EARNINGS
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			**WK OF INJURY**		
17			35			**23. TOTAL EARNINGS**		**$**
18			36			**24. GROSS AVERAGE WEEKLY WAGE**		**$**

COMMENTS:

25. PREPARER'S FULL NAME (REQUIRED):	26. TELEPHONE NUMBER (REQUIRED):	27. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.