INTERGOVERNMENTAL RISK MANAGEMENT AGENCY
Four Westbrook Corporate Center, Suite 940
Westchester, IL 60154
(708) 562-0300
(708) 562-0900 – Claims Fax

WORKERS COMPENSATION WAGE STATEMENT

Complete and submit with Form 45: Employer's first report of injury or illness for all lost time workers' compensation claims. State Employee's wages for the 52 weeks of employment immediately preceding the date of accident.

EMPLOYEE:	**DATE OF ACCIDENT/INJURY:**
CLAIM NUMBER:	**MEMBER:**
DATE EMPLOYED:	**DATE EMPLOYEE CEASED TO WORK:**

Week	Time Period From	To	Regular Hours Worked	O.T. Hours Worked	Amt. Paid Excl. O.T.	Overtime Paid	Week	Time Period From	To	Regular Hours Worked	O.T. Hours Worked	Amt. Paid Excl. O.T.	Overtime Paid
01							27						
02							28						
03							29						
04							30						
05							31						
06							32						
07							33						
08							34						
09							35						
10							36						
11							37						
12							38						
13							39						
14							40						
15							41						
16							42						
17							43						
18							44						
19							45						
20							46						
21							47						
22							48						
23							49						
24							50						
25							51						
26							52						
Subtotal							**Sutotal**						
							Grand Total						
							Average						

Number of hours this employee Scheduled to work per week :

Is employee paid by hour, day, week, or month? At what rate?

Completed by:

(Name) **(Title)**

(Date)