WORKERS' COMPENSATION NOTICE THAT

Employer: ____

has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: ____

Policy Number: ______________________________

Address for the above insurance carrier is ____

Telephone number is ________________________

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury - no matter how slight - to your boss immediately. (You may lose your rights if your injury is not reported within 180 days of injury or work related illness.)

2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.

3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.

4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.

2. Ask your doctor to send a medical report to that insurance company.

3. Ask your employer to send a report of the accident to that insurance company.

4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH

LABOR COMMISSION

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610

(801)530-6800 – (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers.

NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.

COMPENSACIÓN AL TRABAJADOR
NOTE QUE

La empresa: ____

Ha cumplido con las provisiones del Acta de Compensación al Trabajador, Titulo §34A-2-101, en el libro de Código de Utah anatado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensactión y otros beneficios preve idos por el Acta ya mencionada al tener cobertura con.

Compañía de Seguros: ____

No. de Póliza: ____

Dirección de la compañía de seguros: ____

Numero de teléfono: ____________________________

COMPENSACIÓN AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTÉGÉ DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS * INCAPACIDAD * PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO * PROTESIS * GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UNACCIDENTE

1. Reporte la lesión – no importa que tan leve sea – a su supervisor immediatamente. (Pierde sus derechos si no reporta su accidente entre 180 dias después del incidente.)

2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión Laboral a la compania de seguro dentro De los primeros siete (7) dias del accidente.

3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la companía, vaya inmediatemente para obtener tratamiento, Si no, vaya al doctor de su preferencia.

4. Digale al doctor **CÓMO, CUÁNDO Y DÓNDE** ocurrió el accidente. El doctor llenara una forma de reporte médico. Copias de ese reporte deben se enviadas dentro de siete (7) dias de su visita a (1) la compañia de seguros, (2) La Comisión Laboral (3) usted, el empleado.

COMO EMPREZAR LA COMPENSACIÓN

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.

2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.

3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.

4. Llame a la compañía de seguros y pidales que empiecen sus beneficios de compensación al trabajador. La compania de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION – LLAME A LA COMPAÑIA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah require lo siguiente que aparezca en esta forma, cualquier persona que intensionalmente presente información false o fraudulenta, que abara o cause que sea abierto un caso fraudulento de disabilidad o beneficios médicos, o que entregue un reporte fraudulento de factusas de gastos médicos u otros servicios profesionales es calpable de crimen y puede ser sujeto a multas y encarceuado en la prisión del Estada."

ESTADO DE UTAH

COMISION LABORAL

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610

(801)530-6800 – (800)530-5090

Si desea una Guía del Empleado para Compensacion al Trabajador o si tiene preguntas, llame a la Comisión Labor a los números mencionados arriba.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Articulo §34A-2-204, en el libro de Código de Utah anatado en 1997.

Form 307 I

MEDICAL TREATMENT PROVIDER LIST

PLEASE PRINT OR TYPE

Claimant Name ________________________ Social Security Number ________________________

Address ______________________________ Date of Injury ________________________________

______________________________ Employer ____________________________________

Telephone ____________________________

"Notification to the Workers' Compensation Claimant"

Per Labor Commission Rule R612-2-22, an injured worker who files a claim for workers' compensation benefits is required, if requested, to provide the name and address of medical providers who have provided any medical treatment for up to the past 10 years (15 years if Permanent Total claim or in Adjudication). This is your notice that any and all of the medical records within the custody of the medical provider that you have listed may be requested by the party named on this form, as authorized by Rule R612-2-22. The medical provider is required to release the medical records per the rule, in order for the insurance carrier, self-insured employer, or the Labor Commission to make a determination in your case. *You are required to sign the "Authorization to Release Medical Records" Form 308 I.

Please list all the medical providers for industrial injury first. Please list any other medical providers who have treated you for <u>any</u> medical problems within the past 10 years (up to 15 years).

____ ____

____ ____

____ ____

Telephone Number ________________________ Telephone Number ________________________

____ ____

____ ____

____ ____

Telephone Number ________________________ Telephone Number ________________________

____ ____

____ ____

____ ____

Telephone Number ________________________ Telephone Number ________________________

Please attach additional pages, if necessary.

<u>Name of Party Requesting</u> the Medical Records ____

Address ____

Telephone Number ________________________ **Fax Number** ____________________________________

Relationship to claim ____

Medical Providers who have treated you related to your reproductive organs or for psychological problems do <u>not</u> have to be listed unless you have made a claim for benefits related to those medical problems.

Please forward this form to the Requesting Party at the above listed address/fax number.

FORM 122

For your protection Utah Law requires notice that worker's compensation fraud is a crime. Please see back of this form for the full fraud statement.

WORKER'S COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
STATE OF UTAH - THE LABOR COMMISSION - DIVISION OF INDUSTRIAL ACCIDENTS
160 E 300 S, P.O. BOX 146610
SALT LAKE CITY, UTAH 84114-6610

GENERAL

EMPLOYER (Name & Address Incl. Zip)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER / CLAIMS ADMIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE#)	POLICY PERIOD ___ TO ___	CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)
	CHECK IF APPROPRIATE ☐ SELF-INSURANCE	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME AND CODE NUMBER

EMPLOYEE / WAGE

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE

ADDRESS (INCL ZIP)	SEX	MARITAL STATUS	OCCUPATION / JOB TITLE
	M MALE	U UNMARRIED SINGLE/DIVORCE	EMPLOYMENT STATUS
	F FEMALE	M MARRIED	
	U UNKNOWN	S SEPARATED	
PHONE	# OF DEPENDENTS	K UNKNOWN	NCCI CLASS CODE

RATE	PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO	DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY / ILLNESS	PART OF BODY AFFECTED
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY / ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED / CAUSE OF INJURY CODE

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAMES & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT
		1 MINOR: BY EMPLOYER
		2 MINOR CLINIC/HOSP
		3 EMERGENCY CARE
		4 HOSPITALIZED > 24 HRS
		5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

SEE BACK FOR IMPORTANT INFORMATION

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Labor Commission   W.C. Insurance Carrier   Employee   Employer's File

FRAUD - "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison"

INSTRUCTIONS TO EMPLOYER

The Employer's First Report of Injury or Illness must be submitted to the Labor Commission, Division of Industrial Accidents, per Sections §34A-2-407 and §34A-3-10B, Utah Code Annotated (U.C.A.), 1997. Each employer shall file the report within **seven days** after the occurrence, or the employee's notification of the same, which results in medical treatment by a physician, loss of consciousness, loss of work, restriction of work, or transfer to another job. Each employer shall file a subsequent report with the commission of any previously reported injury; or occupational disease that later resulted in death. Also, for your information, Section §34A-6-301(3)(b)(ii) states that each employer shall, within 12 hours of occurrence, notify the Division of Occupational Safety and Health, at (801) 530-6901 or (800) 530-5090, of any; work related fatality; disabling, serious, or significant injury; or occupational disease incident. A serious injury includes: amputation, fractures of major bones (both simple and compound), and hospitalization for medical treatment.

* All information requested on this form is of vital importance. Please answer **all** items in detail in order to avoid additional correspondence or the return of this report for completion. **Do not enter data in the shaded areas.**

* The box titled "OSHA Log Number" must be filled in with the employer assigned Case Number from OSHA's new 300 Injury Log. The Case Number needs to reflect the year of the injury - for example, your first injury in 2002 should reflect the first injury and the year 00/02 with the next injury being 00202 etc.

* Please provide **WAGE** information. This information is needed by the insurance company for paying the correct amount on a claim.

* The injury report on file with the Labor Commission, Division of Industrial Accidents, is private information and is only released to parties to the claim.

* Please make sure the **EMPLOYER NAME** is correct, as well as your **FEIN#** (Federal Tax ID Number). The employer's name should be the same as reported to The Department of Workforce Services and as it appears on your WORKERS' COMPENSATION insurance policy.

* **The Labor Commission** is to receive the **original** of this report, **Worker's Compensation Insurance Carrier** gets the **second** copy, the **employee** gets the **third** copy, and the **employer** gets the **fourth** and should maintain a copy of this report.

* Failure to file this report with the Labor Commission or failure to provide the employee with copy of the report, is a Class C misdemeanor and can also result in a citation and a civil penalty for each violation as per §34A-2-407(7), §34-a-3-108(7), §34A-6-302, and §34A-6-307, U.C. A.

* If you dispute the validity of this claim you need to contact your insurance carrier, but you must still file the "Employer's First Report of Injury or Illness" form with the Labor Commission.

* **Reminder**: Inform your injured employee of his/her rights and obligations (as outlined on the back of the employee's copy) of Utah's Workers' Compensation Act.

For additional information please contact:

State of Utah - Labor Commission
Division of Industrial Accidents
160 East 300 South, 3rd Floor
P.O. Box 146610
Salt Lake City, Utah 84114-6610

FRAUD - “Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.”

EMPLOYEE INFORMATION

- **INJURY/ILLNESS REPORT**: A report of your injury/ occupational illness must be made with your employer. If a report of injury is not filed with your employer or the Labor Commission, Division of Industrial Accidents, within 180 days of the date of your injury/illness, you may lose the right to ever file a claim for workers’ compensation benefits for that injury or illness.

- **EMPLOYER’S PHYSICIAN:** If your employer has a company physician or designated clinic for industrial accidents, you MUST see the company physician first, or you may not be eligible for workers’ compensation benefits. After you have been seen by your employer’s physician, you have the right to choose one treating physician.

- **MEDICAL COOPERATION:** You must cooperate with your employer or the insurance carrier in following prescribed medical treatment in order to return to work as quickly as possible.

- **TRAVEL REIMBURSEMENT:** You may be eligible for travel reimbursement to and from approved medical care. You will need to keep records. Contact your insurance carrier regarding travel expenses.

- **REEMPLOYMENT ASSISTANCE:** You may be eligible for reemployment assistance if you are unable to return to work due to an industrial injury. Contact your insurance carrier or the Labor Commission, Division of Industrial Accidents, for further information.

- **MEDICAL EXPENSES:** You are entitled to have all reasonable medical expenses paid that are a result of the injury or illness.

- **COMPENSATION BENEFITS:** You are entitled to 66-2/3 of your wages up to 100% of the state average weekly wage (as of the date of your injury) after 3 days from the date of your injury, if a physician states you are totally unable to work.

    ☐ If you have sustained a permanent impairment due to the industrial injury or disease, you are entitled to compensation based on the impairment rating as determined by a physician.

    ☐ If you are permanently totally disabled from working due to the industrial injury, you may need to apply at the Labor Commission, Division of Industrial Accidents, for a hearing to determine if benefits are due.

- **ADDITIONAL ASSISTANCE:** If you are unable to work due to an industrial injury and meet the program’s requirements, you may be eligible for other assistance. Agencies you may wish to contact:

    ☐ Department of Workforce Services for food stamps, cash assistance, medical assistance, or employment assistance
    ☐ Social Security for total disability benefits

- **UNEMPLOYMENT BENEFITS:** If you are able to work, but have been terminated from your job, you need to apply at the nearest Department of Workforce Services employment office within 90 calendar days after you are released for full-time work by your doctor.

Contact your insurance carrier if problems occur during your injury regarding payment of medical bills or compensation payments. If you need to know who your employer’s insurance carrier is, your may ask your employer or contact the Labor Commission, Division of Industrial Accidents.

For further information or assistance contact:
Labor Commission - Division of Industrial Accidents
160 East 300 South 3rd Floor, P.O. Box 146610, Salt Lake City, Utah 84114-6610
(801) 530-6800, 1 (800) 530-5090

THIS IS AN IMPORTANT DOCUMENT TO MAINTAIN FOR YOUR RECORDS

Utah State Labor Commission
Wage Claim Unit
160 East 300 South, 3rd Floor
P O Box 146630
Salt Lake City, Utah 84114-6630
Telephone no. 801-530-6801 Toll Free: 1(800) 530-5090
Fax Number: 801-530-6282
Hours: Monday-Thursday 7:00 am to 6:00 pm
Web site: www.laborcommission.utah.gov

FORM 401
1/11

WAGE CLAIM NO. ____________
For Office Use Only

WAGE CLAIM ASSIGNMENT

This Form Must Be Completed in its Entirety.
A copy of this claim will be sent to the employer.
Claims must be at least $50.00, U.C.A. Section 34-28-9(1)(c).
Claims may not exceed $10,000, U.C.A. Section 34-28-9(1)(d).
Claims must be filed within one year of when the upaid wages were earned, U.C.A. Section 34-28-9(1)(e)

PLEASE PRINT ALL INFORMATION

Claimant Information

Your Name (Mr.) (Ms.) ______________________________

Mailing Address ______________________________ Apt # __________

City ______________________ State __________ Zip Code __________

Telephone No. __________________ Date of Birth __________________

Name, address and telephone number of nearest relative not living with you. __________

____

Information About Employer

Name of business ______________________________

Mailing Address ______________________ City __________________

State __________ Zip Code __________ Telephone No. __________________

Owner's name __________________ Type of business __________________

Owner's home address ______________________________

Wages Claimed

Total amount of your claim (before tax or social security deductions) $ __________

Is claim for: Unpaid wages $________ Commission $________ Bad paycheck (net) ________

Unauthorized deduction(s) $________ Vacation pay $ ________ Severance pay $ ________

Other $ ________ (explain) ______________________________

(PLEASE NOTE:)
If claim is for vacation or severance pay, please provide a copy of employer's company policy.
If claim is for a bad paycheck(s), please provide this office with the original check(s).
If claim is for an unauthorized deduction(s), please provide check stub(s) showing deduction(s).

Employment Information

Who was your immediate supervisor? ____

Did you quit? Yes ________ No _________ Were you discharged? Yes ________ No _________

Why? Explain ____

Did you ask for your wages? Yes ________ No ________ If yes, on what date? _______________

Please list date(s) and times you worked to earn the wages you are claiming: _____________________

____

State the facts leading up to the wage dispute: (Reason for non-payment.) _______________________

____

____

ASSIGNMENT

I hereby certify that this is a true statement of wages due me to the best of my knowledge and belief. I understand that acceptance of this claim by the Wage Claim Unit of the Labor Commission does not guarantee collection. I hereby assign the said wages to the Labor Commission to collect in accordance with the Utah Labor Code.

I agree to appear at any hearing called by the Labor Commission to consider my claim. Failure to do so will be reason for dismissal of my claim. If the Labor Commission or its agents conclude that a compromise settlement is necessary to reach an equitable settlement, I authorize the Labor Commission to execute the same and my failure to accept may result in dismissal of my claim.

I authorize the Labor Commission or its agents to receive any U.S. currency, checks or money orders obtained as payment of this claim. If I do not call at this office for money paid on this claim, I authorize the mailing of same, at my own risk. I understand that neglect on my part to keep in touch with the Labor Commission may result in dismissal of my claim.

THIS IS A SWORN STATEMENT

I hereby swear that I am the Claimant in this action, or that I am the authorized agent of the Claimant in this action.

I further swear that the information contained in this form is true to the best of my knowledge.

_______________ ____________________________________

Date Signature of Claimant or Agent

Important: If an authorized agent is filing on behalf of the Claimant, the Claimant must sign the following statement OR a copy of the document establishing the agent's authority to act on the Claimant's behalf.

I HAVE AUTHORIZED_________________________TO ACT ON MY BEHALF IN FILING THIS WAGE CLAIM.

(Name of Agent)

________________ __________________________

Date Signature of Claimant

PLEASE PRINT

CLAIMANT'S NAME ____

Who hired you? ____ Date hired? ______________

What type of work did you perform? ____

Address where work was performed ____

Date of last day you worked ____

Is the employer still in business? Yes ________ No _________

What rate of pay did you and your employer agree to? Hourly ________ Weekly ________

Bi-Weekly ________ Semi-Monthly ________ Monthly ________ Other (explain) ______________

Was this agreement Oral ____________ Written ____________

Did you sign any contract or agreement with this employer? Yes ________ No ________

If YES, explain ____

How often were you paid? Weekly _______ Bi-weekly ________ Semi-Monthly _________

Other (Explain) ____

What were the dates of your regularly scheduled paydays? __________________________________

How were you paid? By Check _________ Cash _________ Electronic transfer _________

Other (explain) ____

Did your employer deduct social security and withholding taxes? Yes _________ No _________

Did you sign any authorization for other deductions? Yes _________ No _________

Did your employer set regular working hours? Yes _________ No _________

Are you covered by a union contract? Yes _________ No _________

If your claim is for COMMISSIONS, what was the percentage you were to receive? _______________

What was the total amount of sales, etc. on which commissions were not paid? $_________________.

(Please attach an itemization of the sales to this claim.)

What was the employer's agreement for the time of payment? Explain fully: _____________________

____

On what date(s) was this work performed? ____

If your claim is for DEDUCTION(S), explain why the deduction(s) was made _____________________

____

Date(s) of pay period(s) on which deduction(s) was made ____________________________________

If your claim is for OTHER, explain how you arrived at the amount of your claim ___________________

____

Include a copy of written policy or if unwritten, explain fully ______________________________________

____

Date(s) work was performed to earn wages ____

Do you owe any money to the employer? Yes _______ No _______ If yes, explain ______________
____
Do you have any of the employer's property? Yes ______ No ______ If yes, explain _____________
____
Reason given by employer for nonpayment of wages: ____
____

If you worked for a subcontractor, who was the prime/general contractor? (Only for statistical purposes)

COMPANY'S NAME ____
ADDRESS ____
TELEPHONE NUMBER ____
PROJECT NAME or ADDRESS WHERE WORK WAS PERFORMED ___________________________
____