

**State of Rhode Island
REPORT OF SPECIFIC PAYMENT**

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8084

DWC No. _____

Insurer File No. _____

YOU MUST CHECK ONE OF THE FOLLOWING:

LOST TIME NO LOST TIME FEDERAL JURISDICTION

1. EMPLOYEE: SSN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Date of Birth _____	2. EMPLOYER: FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____
3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____ RI License Number _____	4. CLAIM ADMINISTRATOR: <input type="checkbox"/> SAME AS BLOCK 3 FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____ RI License or Self-Insurance Number _____

5. CLAIM INFORMATION:

Injury date _____ Incapacity date (if appropriate) _____

Average Weekly Wage (including OT) _____ Weekly Specific Rate _____

Specific paid by: Court Order Date: _____ Number: _____ OR Agreement of the Parties

Description of Injury/Specific: _____

Attorney Fee: _____

6. SPECIFIC PAYMENT INFORMATION:

Indicate Payment Type	Body Part	Percent of Loss	Number of Weeks	Amount Paid	Date Paid
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					

Hearing Loss		Total/Partial Deafness		Number of Weeks	Amount Paid	Date Paid
Left Ear	<input type="checkbox"/> occupational <input type="checkbox"/> traumatic	<input type="checkbox"/> total	<input type="checkbox"/> partial			
Right Ear	<input type="checkbox"/> occupational <input type="checkbox"/> traumatic	<input type="checkbox"/> total	<input type="checkbox"/> partial			

Employee Signature: _____ (Not required for Court Order)	Date: _____	Employer/Insurer Signature: _____	Date: _____
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