

**State of Rhode Island  
SUSPENSION AGREEMENT AND RECEIPT**

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) 462-8006

DWC No. \_\_\_\_\_

Insurer File No. \_\_\_\_\_

**1. EMPLOYEE INFORMATION:**

SSN \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_

**2. CLAIM INFORMATION:**

Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Claim Administrator \_\_\_\_\_  
Injury date \_\_\_\_\_  
Incapacity date \_\_\_\_\_

We agree that weekly compensation which began on \_\_\_\_\_ (date of incapacity) will end as of \_\_\_\_\_ (date paid through). Payment of medical bills related to this injury may continue. Completing and signing this form does not prevent the employee from claiming future weekly compensation benefits in the event that the employee is unable to work due to this injury.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Employer or Insurer Signature: \_\_\_\_\_

Date: \_\_\_\_\_