

KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS

CLAIM NO. _____

PLAINTIFF/EMPLOYEE

VS

WAGE CERTIFICATION

DEFENDANT/EMPLOYER

1. Date of Injury/Exposure as reported on Claim Form _____

2. Method of Wage Payment (check one):

- | | |
|---|--|
| <input type="checkbox"/> Hourly Amount _____ | <input type="checkbox"/> Daily Amount _____ |
| <input type="checkbox"/> Weekly Salary Amount _____ | <input type="checkbox"/> Monthly Salary Amount _____ |
| <input type="checkbox"/> Yearly Salary Amount _____ | <input type="checkbox"/> Output of Employee Amount _____ |

3. Date of Hire or Employment: _____

4. Name of concurrent employer: _____.

5. Did Employer provide any of the following (check appropriate ones):

- | | | |
|----------------------------------|-------------------------------|----------------------------------|
| <input type="checkbox"/> Board | <input type="checkbox"/> Rent | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Lodging | <input type="checkbox"/> Fuel | |

6. Did Employee (check appropriate ones):

- | | | |
|--|---|---|
| <input type="checkbox"/> Work Overtime | <input type="checkbox"/> Receive Gratuities | <input type="checkbox"/> Paid Vacation/Holidays |
|--|---|---|

Plaintiff/Employee's Name: _____

Claim Number: _____

<u>Weeks Worked</u> <u>Month/Day/Year</u>	<u>Total Regular</u> <u>and Overtime</u> <u>Hours Worked</u>		<u>Regular</u> <u>Hourly Rate</u>		
1. _____	_____	X	_____	=	_____
2. _____	_____	X	_____	=	_____
3. _____	_____	X	_____	=	_____
4. _____	_____	X	_____	=	_____
5. _____	_____	X	_____	=	_____
6. _____	_____	X	_____	=	_____
7. _____	_____	X	_____	=	_____
8. _____	_____	X	_____	=	_____
9. _____	_____	X	_____	=	_____
10. _____	_____	X	_____	=	_____
11. _____	_____	X	_____	=	_____
12. _____	_____	X	_____	=	_____
13. _____	_____	X	_____	=	_____

Total: \$ _____

÷ by 13 weeks = \$ _____

14. _____	_____	X	_____	=	_____
15. _____	_____	X	_____	=	_____
16. _____	_____	X	_____	=	_____
17. _____	_____	X	_____	=	_____
18. _____	_____	X	_____	=	_____
19. _____	_____	X	_____	=	_____
20. _____	_____	X	_____	=	_____
21. _____	_____	X	_____	=	_____
22. _____	_____	X	_____	=	_____
23. _____	_____	X	_____	=	_____
24. _____	_____	X	_____	=	_____
25. _____	_____	X	_____	=	_____
26. _____	_____	X	_____	=	_____

Total: \$ _____

÷ by 13 weeks = \$ _____

<u>Weeks Worked</u> <u>Month/Day/Year</u>	<u>Total Regular</u> <u>and Overtime</u> <u>Hours Worked</u>		<u>Regular</u> <u>Hourly Rate</u>	=	
27. _____	_____	X	_____	=	_____
28. _____	_____	X	_____	=	_____
29. _____	_____	X	_____	=	_____
30. _____	_____	X	_____	=	_____
31. _____	_____	X	_____	=	_____
32. _____	_____	X	_____	=	_____
33. _____	_____	X	_____	=	_____
34. _____	_____	X	_____	=	_____
35. _____	_____	X	_____	=	_____
36. _____	_____	X	_____	=	_____
37. _____	_____	X	_____	=	_____
38. _____	_____	X	_____	=	_____
39. _____	_____	X	_____	=	_____

Total: \$ _____

÷ by 13 weeks = \$ _____

40. _____	_____	X	_____	=	_____
41. _____	_____	X	_____	=	_____
42. _____	_____	X	_____	=	_____
43. _____	_____	X	_____	=	_____
44. _____	_____	X	_____	=	_____
45. _____	_____	X	_____	=	_____
46. _____	_____	X	_____	=	_____
47. _____	_____	X	_____	=	_____
48. _____	_____	X	_____	=	_____
49. _____	_____	X	_____	=	_____
50. _____	_____	X	_____	=	_____
51. _____	_____	X	_____	=	_____
52. _____	_____	X	_____	=	_____

Total: \$ _____

÷ by 13 weeks = \$ _____

CERTIFICATION

I certify that the above wage information is a true and accurate accounting of my wages from the concurrent employer(s) identified above for the fifty-two (52) weeks prior to the date of injury/last exposure set forth in the Claim form.

Plaintiff/Employee

Signature

Date

CERTIFICATE OF SERVICE

It is hereby certified that the original of this wage certification was mailed this _____ day of _____, 20_____ to the Commissioner and a copy of the same to Counsel of record and the assigned Administrative Law Judge.

**Attorney for the Plaintiff/Employee or
Plaintiff/employee**