First 26 Weeks
Wage Reimbursement Form

Claim Number: _____

Injured Worker: _____

Date From: _____ Date To: _____

Number of Working:
(Days/hours employer is claiming for when worker has not been at work)

Days: _____ Hours: _____

1. Normal Weekly Earnings: $ _____
   (As per our letter)

2. Less Earnings: $ _____
   (Amount paid for hours worked)

3. Balance: $ _____
   (1-2=)

Employer Paid the Worker (2+3) $ _____

Please reimburse $ _____ as indicated above.
Balance (#3)

Signature _____ Date _____