

EMPLOYMENT STATUS REPORT

STATE OF MAINE

WORKERS' COMPENSATION BOARD

STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:		6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:		8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:		11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:		12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:		16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYEE

THIS REPORT IS DUE 90 DAYS AFTER THE DATE OF INJURY, AND EVERY 90 DAYS THEREAFTER, PURSUANT TO 39-A M.R.S.A. § 308 (2). ANY EMPLOYER REQUESTING A QUARTERLY REPORT MUST PROVIDE THE EMPLOYEE WITH THIS REPORT AT LEAST 15 DAYS PRIOR TO THE DATE ON WHICH IT IS DUE. **FAILURE TO COMPLETE AND RETURN THIS REPORT MAY RESULT IN THE DISCONTINUANCE OF YOUR WORKERS' COMPENSATION BENEFITS.**

THIS REPORT IS DUE: _____, 19 _____

THIS REPORT COVERS THE PERIOD FROM _____, 19 _____ TO _____, 19 _____

THIS COMPLETED REPORT SHOULD BE RETURNED TO:

PART 2 (COMPLETED BY THE EMPLOYEE)

19.

A. DID YOU WORK OR PERFORM ANY SERVICES FOR PAY OR OTHER BENEFIT DURING THE PERIOD STATED IN THE ABOVE SECTION? YES NO

B. IF YES, COMPLETE THE FOLLOWING AND **ATTACH VERIFICATION OF INCOME** (USE REVERSE SIDE IF NECESSARY):

EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

C. WHAT TYPE(S) OF WORK DID YOU PERFORM IN THIS EMPLOYMENT?

D. DATES EMPLOYED: FROM: _____, 19 _____ TO _____, 19 _____

E. ARE YOU STILL EMPLOYED? YES NO

20. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

EMPLOYEE SIGNATURE

DATE