

**Department of Workforce Development  
 Worker's Compensation Division**  
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 Fax: (608) 267-0394  
<http://www.dwd.wisconsin.gov/wc>  
 e-mail: DWDDWC@dwd.wisconsin.gov

**STIPULATION**

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.  
 Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number		Employee Name	Employee Birth Date
Employee Social Security Number		Employee Mailing Address (Number, Street)	
Employee Mailing Address (City, State, Zip Code)			
Date of Alleged Injury	Employer Name	Employer Mailing Address (Number, Street)	
Employer Mailing Address (City, State, Zip Code)			
Insurance Company Name		Insurance Company Address (Number, Street)	
Insurance Company Address (City, State, Zip Code)			

Employee's Average Weekly Wage at Time of Injury: \$ \_\_\_\_\_

**Temporary Disability:**

From	To
From	To
From	To

Permanent Disability Conceded %: \_\_\_\_\_ Weeks \_\_\_\_\_ \$ \_\_\_\_\_

Compensation Paid \$ \_\_\_\_\_ Attorney Fee \$ \_\_\_\_\_

**Medical Expenses to be Paid:**

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Employee Signature	Date Signed
Insurance Co. Representative or Self-Insured Employer Signature	Date Signed

Note: Attach all medical reports.