

STATEMENT OF SELF-RESTRICTION TO PART-TIME WORK

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].

EMPLOYEE NAME:

EMPLOYEE S.S. #:

DATE OF INJURY:

This form is needed to properly compute the wage for your Worker's Compensation benefits.
Please answer the following questions, sign, date and return to your insurance carrier or self-insured employer.

1. At the time of your injury, did you limit your availability in the labor market to part-time work or to work only with the employer where you were injured ?
 Yes No

If yes, explain your limitation:

2. At the time of your injury, were you also employed by another employer or self-employed?
 Yes No

If Yes, please provide us with the name and address of your other employer below:

Employer Name:

Employer Address:

Signed _____ Phone Number: (_____) _____
Area Code

Dated _____