

## STATEMENT OF SELF-RESTRICTION TO PART-TIME WORK

Department of Workforce Development  
Worker's Compensation Division  
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\*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 \_\_\_\_\_