Department of Workforce Development
Worker's Compensation Division
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P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 267-0394
https://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.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

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.