

Instructions for Completing the Calendar of Wages

This report must be submitted with all employee applications for benefits.

- Complete the employee's full name, the Bureau of Workers' Compensation claim # if available, employer name, date of injury
- Complete the form starting with the date of injury and be sure to note the date the employee last worked and the return to work date. If the employee has not returned, please do not use N/A, indicate not yet or an estimated return to work date (ERTW)
- Check the type of benefit the employee is requesting – OIL, SC, TT or disability
- Please indicate if the employee has a fixed schedule or a floating schedule (schedule varies from week to week or changes every other month, etc.)
- Please indicate how many hours a day the employee works and the shift
- If the employee has a fixed schedule, it is imperative to complete the calendar for the week of the injury and the subsequent week
- If the employee has a floating schedule, it is imperative to complete the calendar for the days through the estimated return to work date

ONLY use the codes listed on this form (ADM4741). This will prevent delays and errors in decisions. Because you are completing this form for future benefits, if the employee requested SC, use the SC code for time off.

A – Absent, no pay
 ADM – Administrative Leave
 CSD – Cost Savings Day
 CT – Comp Time
 DL – Donated Leave
 DOI – Date of Injury

ERTW – Estimated Return to Work
 H – Holiday
 LDW – Last Day Worked
 LOA – Leave of Absence
 OIL – Occupational Injury Leave
 PL – Personal Leave

R – Regular Day Off
 RTW – Date Returned to Work
 S – Sick Leave
 SC – Salary Continuation
 TWP – Transitional work
 V – Vacation
 W – Worked

SAMPLES

5/12	5/13	5/14	5/15	5/16	5/17	5/18
W 8	W 8	R	R	W 8	DOI LDW W-6 SC-2	SC 8
5/19	5/20	5/21	5/22	5/23	5/24	5/25
SC 8	R	R	SC 8	SC 8	ERTW	

5/12	5/13	5/14	5/15	5/16	5/17	5/18
R	R	W 8	DOI LDW W-3 SC-5	SC 8	SC 8	RTW



Calendar of Wages

To be completed for all employees filing for workers' compensation benefits.

Employee Name: _____

BWC Claim #: _____

Employer: _____

Date of Injury: _____

Date employee last worked: _____

Date employee returned to work: _____

Employee has filed for: _____ OIL

_____ Salary Continuation (SC)

_____ WC - TTD

_____ DAS - Disability Benefits

Employee's work schedule: _____ FIXED schedule

_____ FLOATING schedule

Employee normally works # hours per day: ____ 8 ____ 10 ____ 12 ____ other, if other note #: ____

Employee works: ____ 1st shift ____ 2nd shift ____ 3rd shift ____ Other-please explain _____

On the calendar below, starting with the date of injury, please indicate the type of leave used on each day.

ONLY use the codes listed below

A – Absent, no pay

ERTW – Estimated Return to Work

R – Regular Day Off

ADM – Administrative Leave

H – Holiday

RTW – Date Returned to Work

CSD – Cost Savings Day

LDW – Last Day Worked

S – Sick Leave

CT – Comp Time

LOA – Leave of Absence

SC – Salary Continuation

DL – Donated Leave

OIL – Occupational Injury Leave

TWP – Transitional work

DOI – Date of Injury

PL – Personal Leave

V – Vacation

W - Worked

For the period of: _____

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Printed Name of Preparer:	Phone #:
Signature of Preparer:	Date:

NOTICE: Failure to complete a *Calendar of Wages* for all workers' compensation claims, especially requests for Occupational Injury Leave and Salary Continuation, may result in the delay of benefits to the injured workers.

Once completed, fax directly to Third Party Administrator at **614-764-1749**.