

# 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  
 \_\_\_\_\_ WC - TTD

\_\_\_\_\_ Salary Continuation  
 \_\_\_\_\_ 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: \_\_\_\_\_ 1<sup>st</sup> shift \_\_\_\_\_ 2<sup>nd</sup> shift \_\_\_\_\_ 3<sup>rd</sup> 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  
 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

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 printed, complete the form and fax directly to CompManagement, DAS' Third Party Administrator at 614.764.1749

# Instructions Page for Completing the Calendar of Wages

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

- Complete the employee’s full name, the Bureau of Workers’ Compensation claim # if available, employer name, data of injury
- Complete the date the employee last worked and return to work date. If the employee has not returned, please do not use N/A, indicated not yet or an estimated return to work date (ERTWD)
- 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 the ADM4741.**

**This will prevent delays in decisions. This will prevent 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  
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 LDW – Last Day Worked  
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### SAMPLES

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