WC-6 WAGE STATEMENT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address		
E-mail Address		City	State	Zip Code
EMPLOYER	Name	Address		
E-mail Address		City	State	Zip Code

INSURER/ SELF-INSURER	Name		SBWC ID# (five digit number)		
CLAIMS OFFICE	Name	Claims Office Address			
E-mail Address		Insurer/Self-Insurer File #	City	State	Zip Code

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

❑ 13 Weeks of Employee's Wages ❑ 13 Weeks of a Similar Employee's Wages ❑ Full Time Weekly Wage of Injured Employee: $_____

CLICK OR RIGHT CLICK THE LINK BELOW FOR THE MOST RECENT VERSION OF THIS FORM

https://sbwc.georgia.gov/document/document/wc-6/download