EMPLOYMENT STATUS REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

PART I (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER

ANY EMPLOYER REQUESTING A QUARTERLY REPORT MUST PROVIDE THE EMPLOYEE WITH THIS FORM AT LEAST 15 DAYS PRIOR TO THE DATE ON WHICH THE REPORT IS DUE , PURSUANT TO 39-A M.R.S.A. §308(2).

19.

NOTICE TO EMPLOYEE

COMPLETE BOXES 20 AND 21AND RETURN THIS REPORT TO THE EMPLOYER LISTED ABOVE. FAILURE TO COMPLETE AND RETURN THIS REPORT MAY AFFECT YOUR WORKERS' COMPENSATION INDEMNITY BENEFITS.

THIS REPORT IS DUE: _____

THIS REPORT COVERS THE PERIOD FROM _____TO _____

PART II (COMPLETED BY THE EMPLOYEE)

20.

A. HAVE YOU BEEN EMPLOYED, CHANGED EMPLOYMENT OR PERFORMED ANY SERVICES FOR COMPENSATION DURING THE PERIOD STATED IN THE ABOVE SECTION?

YES ☐ NO ☐

B. IF YES, COMPLETE THE FOLLOWING FOR EACH EMPLOYER AND ATTACH VERIFICATION OF INCOME:

EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NATURE OF THE EMPLOYMENT OR SERVICES _____

EMPLOYED FROM: _____ TO _____

ARE YOU STILL EMPLOYED? YES ☐ NO ☐

21. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

_____ _____
EMPLOYEE SIGNATURE DATE

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

WCB-230 (eff. 1/1/13)