

BEFORE THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION

**MWCC No.:** \_\_\_\_\_

**CLAIMANT:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_ **DOH:** \_\_\_\_\_

**WAGE STATEMENT**

WEEK	WEEK ENDING	NUMBER OF DAYS	GROSS WAGES	WEEK	WEEK ENDING	NUMBER OF DAYS	GROSS WAGES
1				27			
2				28			
3				29			
4				30			
5				31			
6				32			
7				33			
8				34			
9				35			
10				36			
11				37			
12				38			
13				39			
14				40			
15				41			
16				42			
17				43			
18				44			
19				45			
20				46			
21				47			
22				48			
23				49			
24				50			
25				51			
26				52			
					TOTAL PAID		

Average Weekly Wage: \_\_\_\_\_

Compensation Rate: \_\_\_\_\_