

State of Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

ITEMIZED STATEMENT OF COMPENSATION

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone: (401) 462-8100 TTY (Relay RI): 711

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN or ID

Last four digits only

XXX-XX-_____

Name _____

Address _____

City, State, Zip _____

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Date of death _____

☐ Work-related OR Not ☐3. ☐ Incident Only--No payments made. Complete Section 8 and return to DLT only at above address.*All others continue below.*

4. NONPAYMENT OF WEEKLY INDEMNITY ONLY: Check correct box and complete appropriate information on remainder of form.

☐ Medical Only*

*Payment info must be listed below

☐ Federal Jurisdiction☐ Salary Continuation☐ Denied

Do NOT use Other if claim is Denied

☐ Death--Liability established; no dependents. Payment made to WCAF☐ Other: _____

5. DIAGNOSIS:

Primary Written Diagnosis _____

ICD Code: _____

Secondary Written Diagnosis _____

ICD Code: _____

6. PAYMENT INFORMATION:

(List total amount paid for each appropriate item in both columns)

DATE OF FIRST INDEMNITY PAYMENT: _____

Temporary Partial		Hospital/Treatment Center	
Temporary Total		Independent Medical Exams	
Permanent Total		Pharmaceutical	
Weekly Death Benefits		Chiropractic	
Burial		Diagnostic Testing	
Specific - Disfigurement		Attorney Fees Awarded by Court	
Specific - Loss of Use		Penalties/Interest	
Vocational Rehabilitation		WC Administrative Fund (WCAF)	
Physical Therapy		Settlement	
Occupational Therapy		Deny & Dismiss	
Psychological Services		Other Payments:	
Physicians		Subrogation	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. RETURN TO EMPLOYMENT:

Did the employee return to employment?

☐ Yes☐ No☐ UnknownIf yes, was it with the ☐ same employer OR a ☐ different employer ☐ Unknown

Date Returned: _____

☐ Unknown

8. THIS REPORT WAS PREPARED BY:

PLEASE PRINT

Name _____

RI Adjuster License Number _____

Company Name _____

Address _____

City _____

State _____

Zip Code _____

Telephone _____

Extension _____

Email _____

Signature _____

Date _____

Distribution: DLT, Division of Workers' Compensation; Employee and Attorney; Employer

DWC-50 (Rev. 01/2021)

For instructions visit our web site:

www.dlt.ri.gov/wc

Department of Labor and Training
RHODE ISLAND