State of Rhode Island
ITEMIZED STATEMENT OF COMPENSATION

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. ____________________

Insurer File No. ____________________

1. EMPLOYEE INFORMATION:

SSN ____________________
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**

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

Do **NOT** use *Other* if claim is *Denied*

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	☐ Yes ☐ No

7. RETURN TO EMPLOYMENT: Did the employee return to employment? ☐ Yes ☐ No ☐ Unknown

If 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 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

DLT Department of Labor and Training RHODE ISLAND