Alabama Self-Insured
worker's compensation fund
Sponsored by the Business Council of Alabama

Employer: ____
Employee: ____
Date of Injury: ____
Claim #: ____

Please complete and return this schedule of weekly earnings at your very earliest convenience. The form requires gross earnings to include non-continuing fringe benefits beginning 52 weeks prior to the date of injury. If employment was less than (1) year, please use the total number of weeks employed.

Claims Examiner ____________________________
Date ____________________________

Week No.	Week From Date	Week To Date	Amount Paid	Number of Days Worked		Week No.	Week From Date	Week To Date	Amount Paid	Number of Days Worked
							Brought Forward			
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	Carried Forward					Grand Total				

I certify that the above is a true copy of payroll record of the Employee's earnings as shown on Employer's records.

Signed ________________________________

Date __________________________________

(334) 277-9395 (800) 392-1551
FAX (334) 240-2981

Serviced by: Employer's Claim Management, Inc.
P.O. Box 5614 Montgomery, AL 36103-5614

www.EmployersClaim.com