WC-6 GEORGIA STATE BOARD OF WORKERS' COMPENSATION (7/90) WAGE STATEMENT

Employee's Name (First) (Middle) (Last) Social Security Number	Employee's Phone Number			
Employee's Street Address	City	/_ State	/ ZIP	 Date of Injury
Employer	Insurer			
Address	Address			
State ZIP Phone City	State	ZIP Pho	<u>()</u> ne	City
If the weekly benefit is less than the max immediately preceding the accident. If the weeks, complete this schedule showing weemployment, and write the name of the suse to establish wage loss for temporary	ne employed veekly earni similar empl	e has not be ngs of a sim oyee here: _	en in you ilar emp	ir employ for 13 loyee in the same
SCHEDULE OF WEEKLY EARNINGS		Г		
19 Amount Pal Week Week Amount Pal Total No. From To No. of Including 	rertime or	<u> </u>	Earni	
_ 		<u>'</u> 	 	I
		<u>'</u>	'	
2 ' '	<u> </u>		<u> </u>	
 			1	

