North Carolina Industrial Commission

IC File # _____

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN _____

Employee's Name

Address

City State Zip

( ) - ( ) -
Home Telephone Work Telephone

/ / ☐ M ☐ F / /
Social Security Number Sex Date of Birth

Date of Injury: / /

( ) -
Employer's Name Telephone Number

, ,
Employer's Address City State Zip

Insurance Carrier

, ,
Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Fax Number

Year: **200**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned	
Jan.																																	
Feb.																																	
Mar.																																	
Apr.																																	
May																																	
June																																	
July																																	
Aug.																																	
Sept.																																	
Oct.																																	
Nov.																																	
Dec.																																	
																															Total		

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: $ _____ . _____ .

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS SECTION
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

FORM 22

The undersigned employer of _____ ,
(Name of Employee)

who alleges an injury on the _____ of _____ , **200**
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

_____
Employer

By _____
Authorized Signature

/ /200
Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

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FORM 22