

APPLICATION FOR WAGE CREDIT EMPLOYMENT REHABILITATION FUND

STATE OF MAINE
WORKERS' COMPENSATION BOARD
OFFICE OF MEDICAL/REHABILITATION SERVICES
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

HIRING EMPLOYER

EMPLOYEE

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____

NOTICE TO EMPLOYER

Pursuant to 39-A M.R.S.A. §355(6)(A), the employer must file an application for a wage credit by providing the board, within two (2) weeks after the close of the first 90 days of employment of the employee, with a statement of the total direct wages, earnings or salary the employer paid to the employee for the first 90 days of employment along with such verification as may be required by rule of the board. Within two (2) weeks after the close of the first 180 days of employment, the subsequent employer must provide to the board a supplemental report of the direct wages, earnings and salary for the second 90-day period, along with the required verification.

COMPLETE THE FOLLOWING INFORMATION:

- A. Employee date of hire: _____
- B1. Total direct wages, earnings or salary the employer paid to the employee for the first 90 days of employment (attach verification): _____
- B2. Total direct wages, earnings or salary the employer paid to the employee for the second 90 days of employment (attach verification): _____
- C. Comments: _____

THEREFORE, the employer asks the board for a wage credit pursuant to 39-A M.R.S.A. §355(6).

SIGNATURE OF APPLICANT

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original application to the Workers' Compensation Board at the above address by regular mail.
2. Keep one (1) copy for yourself.

FOR BOARD USE ONLY	
WCB File Number(s):	Claim Administrator:
Calculation of Wage Credit:	Adjuster Name: