MAIL TO: STATE OF ALABAMA
Workers' Compensation Division
Department of Labor
Montgomery, Alabama 36131

THE USE OF THIS FORM IS REQIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS' COMPENSATION LAW

SUPPLEMENTARY REPORT

Please type or print

The original of this form must be filed with this office. Copies will not be accepted.

FIRST PAYMENT ☐ **REINSTATEMENT** ☐ **AMENDED** ☐

1. Employee: _____ 2. Social Security number: _____
3. Employer: _____ 4. Unemployment Compensation Number: _____
5. Date of Injury: _____ 6. Date disability began this period: _____
7. Insurance carrier: _____ 8. Claim # _____ Service Co # _____
9. Name, address and telephone number of office filing this report:

Phone:

Ext:

A.

10. On _____ *(Date of 1st check)* the amount of _____ was paid for the period from _____ thru _____

Average Weekly Wage $ _____ Compensation Rate $ _____ per week.

11. Type of Disability:
Temporary Total ☐ ; Temporary Partial ☐ ; Permanent Partial ☐ ; Permanent Total ☐ ; Fatal ☐ ;

12. If periodic payments are awarded by Circuit Court, give name location and civil action (CV) number and explain:

_____
_____
_____

B.

IF COMPENSATION WAS NOT PAID WITHIN 30 DAYS FROM THE DATE DISABILITY BEGAN, COMPLETE THIS SECTION.

13. Reason for non-payment: Medical Only ☐ ; no lost time, (return to work date) _____
Under investigation ☐ ; reason for prolonged investigation _____
_____
_____

In litigation ☐ ; Under appeal ☐ ;

14. Has compensation been denied and claimant notified? Yes ☐ ; No ☐ ; Reason? _____
_____
_____

Date _____ Signature and Title _____