EMPLOYEE'S MONTHLY REPORT OF EARNINGS

You must submit this report to your employer's workers' compensation insurer within 30 days of your job-related injury, and every 30 days as long as you receive workers' compensation indemnity benefits. You do not have to submit this report if you have only received medical benefits. Your workers' compensation benefits may be suspended if you do not timely submit this report.

Warning: Per L.R.S. 23:1208 of the Louisiana Workers' Compensation Statute, it shall be unlawful for a person, for the purpose of obtaining or defeating any benefit payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. Penalties for violations include imprisonment, fines, and/or the forfeiture of benefits.

DO NOT leave any blanks on this report. Print or type all responses, and use Not Applicable (N/A) or Zero (-0-) where appropriate.

1. The information in this report is true for the period beginning _____, 20___ and ending _____, 20 ____.

2. For the period covered in this report, did you receive a salary, wage, sales commission, or payment, including cash, of any kind? ☐ Yes ☐ No

   If yes, give name and address of employer _____
   If yes, give your gross earnings_____

3. For the period covered in this report, were you self-employed or involved in any business enterprise? **These include but are not limited to** farming, sales work, operating a business (even if the business lost money), child care, yard work, mechanical work, or any type of family business. ☐ Yes ☐ No

   If yes, describe the type of business you are involved in, your job duties, and the amount of income received from the business. _____
   _____

4. Did you perform any volunteer work during the period covered in this report? ☐ Yes ☐ No

   If yes, describe the type of volunteer work you performed. _____

5. Did you receive any unemployment insurance benefits for the period covered in this report? ☐ Yes ☐ No

   If yes, how much? _____ For how many weeks? _____

6. Did you receive any old age insurance benefits under Title II of the Social Security Act? ☐ Yes ☐ No

   If yes, how much? _____

7. Did you receive any Social Security Disability Benefits, retirement benefits, or any other type of disability or government benefits? ☐ Yes ☐ No

   If yes, how much? _____ What type of benefits did you receive? _____

Employee Certification

I certify that I understand the contents of this entire document and understand I am held responsible for this information. I certify my answers are complete and true, and certify my compliance with the Louisiana Workers' Compensation Act.

_____	_____
Print Name Signature	Social Security Number Date
_____	_____(_____) _____
Physical/Street Address City State/Zip	Telephone Number
_____	_____(_____)_____
Date of Injury Claim Number	Insurer Telephone Number