

Send to workers' compensation carrier and the Division:

(name and fax# of carrier)



CLAIM # \_\_\_\_\_

CARRIER'S CLAIM # \_\_\_\_\_

Initial **EMPLOYEE'S MULTIPLE EMPLOYMENT WAGE STATEMENT (DWC Form-003ME)**  
 Amended

If an employee injured on or after July 1, 2002 worked for more than one employer on the date of injury, the employee's Average Weekly Wage (AWW) may include wages earned from employers other than the employer where the injury/illness occurred. The AWW in this situation is the sum of the AWWs based upon the wages from each employer.

**Claim Employer** – Employer for whom the injured employee was working at the time of the on-the-job injury.

**Non-Claim Employer** – Employers other than the claim employer in which the injured employee was employed at the time of the on-the-job injury.

**To report wages from other employers, file this form with the carrier and the Division and attach supporting documentation.**

**NOTICE:** With few exceptions, you as an individual are entitled to request and review information that DWC has collected on its forms about you and are entitled to have DWC correct information about you that is incorrect.

Requests for these services must be submitted in writing to [OpenRecords@tdi.texas.gov](mailto:OpenRecords@tdi.texas.gov) or to:

Open Records  
Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104

All applicable DWC rules can be found at <http://www.tdi.texas.gov>

EMPLOYEE INFORMATION		NON-CLAIM EMPLOYER INFORMATION	
Employee's Name (Last, First, M.I.):		Non-Claim Employer's Business Name:	
Employee's Mailing Address (Street or P.O. Box):		Non-Claim Employer's Mailing Address (Street or P.O. Box):	
City:	State:	ZIP Code:	City:
			State:
			ZIP Code:
Claim Employer Name:	Social Security Number: xxx-xx	Non-Claim Employer's Federal Tax I.D. Number:	
Date of Injury:	Were you working for the Non-Claim Employer on the date of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name and Phone # of Contact Person at Non-Claim Employer:	
I HEREBY CERTIFY THAT THIS WAGE STATEMENT is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and I understand that making a misrepresentation regarding a workers' compensation injury is a crime that can result in fine and/or imprisonment.		I HEREBY CERTIFY THAT THIS WAGE STATEMENT is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules; and the listed wages only include those <b>reportable for federal income tax purposes</b> and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.	
Signature: _____ Date: _____		Signature: _____ Date: _____	
Name of person submitting form if not employee: _____			

SAME OR SIMILAR EMPLOYEE?	
<p>The wage information on this form is for:</p> <p><input type="checkbox"/> The Injured Employee OR <input type="checkbox"/> A Similar Employee (Note – upon Division request, the employee and/or Non-Claim Employer shall identify the similar employee whose wages were provided)</p>	
<p>If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills &amp; wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.</p>	

**NON-CLAIM EMPLOYER WAGES (ONLY THOSE THAT ARE REPORTABLE FOR FEDERAL INCOME TAX PURPOSES)**

-Indicate the **Gross Wages Reportable for Federal Income Tax Purposes** earned in the **13 weeks immediately prior to the date of injury**. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Do not include payments made to reimburse the employee for the use of the employee's equipment or for paying helpers or reimburse travel expenses.

-If the employee is paid on a monthly or semi-monthly basis, the wages earned may be provided for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the wages for the 14 weeks prior to the date of injury may be reported. When setting the periods to report, the reporting periods may be adjusted backwards slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, do not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PERIOD# (Week#, Month#, or Bi-Week#)	1	2	3	4	5	6	7	8	9	10	11	12	13
FROM DATE:													
TO DATE:													
# HOURS WORKED:													
GROSS WAGES EARNED:													

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

