Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Imaging Fax Server: (608) 260-2503
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

STATEMENT OF SELF-RESTRICTION TO PART-TIME WORK

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

EMPLOYEE NAME:

EMPLOYEE S.S. #*:

DATE OF INJURY:

This form is needed to properly compute the wage for your Worker's Compensation benefits. Please answer the following questions, sign, date and return to your insurance carrier or self-insured employer.

1. At the time of your injury, did you limit your availability in the labor market to part-time work or to work only with the employer where you were injured?
☐ Yes ☐ No

   If Yes, explain your limitation:

2. At the time of your injury, were you also employed by another employer or self-employed?
☐ Yes ☐ No

   If Yes, please provide us with the name and address of your other employer below:

   Employer Name:

   Employer Address:

Signed_____ Dated_____

Phone Number: (_____) _____ - _____
Area Code