Employee's Certificate of Dependency Status

☐ Check if this is a corrected report

State of Rhode Island

Department of Labor and Training
Division of Workers' Compensation
P. O. Box 20190
Cranston, RI 02920-0942
Phone (401) 462-8100 www.dlt.ri.gov/wc

DWC claim number: DWC Claim Number

Claim Administrator File Number: Claim Administrator

1. Employee information:		2. Claim Information:	
SSN: XXX-XX- Last 4	☐ Male ☐ Female	Employer Name: Employer Name	
Name: John Doe		Claim Administrator: Claim Administrator File	
Address: 123 Main St. Apt. 1		Address: Address	
City, ST Zip: Anytown NY 12345		City, ST Zip: City, State, Zip	
Phone: 123-456-7890	Date of Birth: 01/01/0001	Injury Date: 01/01/0001	Incapacity Date: 01/01/0001

Employee: complete this form and return it to the Claim Administrator. This information is needed to calculate your compensation rate.

3. Marital Status At the time of the injury the employee was ☐ Single ☐ Married

☐ Spouse works ☐ Spouse does not work Spouse's name: Spouse's Name

4. Number of Federal Exemptions	Ente	Enter the maximum number of Federal Exemptions you are allowed to claim for Federal income tax. Include yourself, your spouse, your dependents, and any other exemptions.

5. Dependents

A dependent for workers' compensation includes children you support who are:
- Under age 18, or age 18 to 23 and a full time student
- Mentally or physically incapacitated from earning at any age

Dependent's Name	Date of Birth	Relationship	Full time student?
1. Dependent's Name	01/01/0001	1.	☐ Yes ☐ No
2. Dependent's Name	01/01/0001	2.	☐ Yes ☐ No
3. Dependent's Name	01/01/0001	3.	☐ Yes ☐ No
4. Dependent's Name	01/01/0001	4.	☐ Yes ☐ No
5. Dependent's Name	01/01/0001	5.	☐ Yes ☐ No
6. Dependent's Name	01/01/0001	6.	☐ Yes ☐ No
7. Dependent's Name	01/01/0001	7.	☐ Yes ☐ No
8. Dependent's Name	01/01/0001	8.	☐ Yes ☐ No
9. Dependent's Name	01/01/0001	9.	☐ Yes ☐ No

Employee's Signature	John Doe	Date	01/01/0001

DWC-04(7/12)