



STATE OF HAWAII  
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
DISABILITY COMPENSATION DIVISION

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

**INSTRUCTION SHEET FOR FORM WC-14  
EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS**

**Instructions**

**Please completely fill out the WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS FORM.**

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

**Please remember to sign and date the form before submitting it.**

**Delivery Information**

**Delivery by U.S. Mail**

Department of Labor and Industrial Relations, Disability Compensation Division  
P.O. Box 3769, Honolulu, Hawaii 96812-3769

**Delivery In-Person**

Department of Labor and Industrial Relations, Disability Compensation Division  
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

**Delivery via Fax**

Department of Labor and Industrial Relations, Disability Compensation Division  
(808) 586-9219



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**FORM WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS**

**EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS  
PRIOR TO DATE OF INJURY**

Employee:	SS No.:	Case No.:	Date of Injury:
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The above employee reported employment with your firm Under the Hawaii Workers' Compensation Law; an employee's benefits are calculated based on wages earned. Please assist us in determining benefits by completing this form

Employer:	Employee's Occupation:	Hourly Rate:				
Date Employed:	Presently Employed?	If terminated, date:				
Disabled from:	through:	Returned to Work:				
Indicate the days and hours normally worked:						
Sunday:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:
If other than the above, please indicate:						

***Please call Records and Claims Branch at 586-9174 if you have Questions***

Employer:	Telephone: ( )
Address	
Date:	By:

(To be signed in ink)

Auxiliary aids and services are available upon request. Please call: (808) 586-9174; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

Employee:	SS No.:	Case No.:	Date of Injury:
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	Dates(inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period	Amount paid excluding overtime or extra work	Overtime or extra work
	From	To	Year				
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
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17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
	Total						

This statement of Employee's earnings is taken from our Payroll Records.

	Dates ( inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period	Amount paid excluding overtime or extra work	Overtime or extra work
	From	To	Year				
27							
28							
29							
30							
31							
32							
33							
34							
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46							
47							
48							
49							
50							
51							
52							
	Total						

This statement of Employee's earnings is taken from our Payroll Records.