



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION

P.O. BOX 58  
JEFFERSON CITY,  
MO 65102-0058

<b>INJURY NUMBER</b>
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**NOTICE OF COMMENCEMENT/TERMINATION OF COMPENSATION**

NOTE: THIS FORM MUST BE TYPED OR HAND PRINTED IN BLACK INK.

INSURER'S OR EMPLOYER'S NAME		CLAIM NO.	
ADDRESS		ZIP CODE	
<p>THIS FORM NEEDS TO BE COMPLETED IF THE EMPLOYEE RECEIVED COMPENSATION BENEFITS AFTER THE THREE DAY WAITING PERIOD AND AS REQUIRED BY §§287.160, 287.170 AND 287.180, RSMo, AND 8 CSR 50-2.010. SEND ORIGINAL TO THE DIVISION AND ONE COPY TO THE EMPLOYEE.</p> <p><b>TO EMPLOYER AND INSURER:</b> BE SURE TO GIVE THE COST OF MEDICAL AID AND FURNISH ALL OTHER DATA ITEMS.</p> <p><b>TO EMPLOYEE:</b> THIS RECEIPT IS REQUIRED BY THE DIVISION OF WORKERS' COMPENSATION, AND YOU ARE REQUESTED TO SIGN IT IF IT COVERS THE PAYMENTS MADE TO YOU. YOUR SIGNATURE IS SIMPLY AN ACKNOWLEDGEMENT OF MONEY PAID AND DOES NOT CONSTITUTE A RELEASE.</p> <p style="text-align: center;"><b>(THIS FORM IS REQUIRED TO BE FILED WITHIN 30 DAYS OF THE DATE OF THE ORIGINAL NOTIFICATION OF THE INJURY. THIS FORM MUST BE UPDATED AND REFILED WITHIN TEN DAYS AFTER TERMINATION OF COMPENSATION.)</b></p>			
1. EMPLOYEE	1A. SOCIAL SECURITY NUMBER	2. DATE OF ACCIDENT	3. COST OF MEDICAL AID
4. EMPLOYEE ADDRESS			ZIP CODE
5. AVERAGE WEEKLY WAGE \$		6. RATE OF COMPENSATION	7. WAITING PERIOD DATES
8. DISABILITY BEGAN	9. DISABILITY ENDED	10. TOTAL WEEKS OF COMPENSATION	
		TEMPORARY TOTAL DISABILITY BENEFITS PAID TO DATE \$	
		TEMPORARY PARTIAL DISABILITY BENEFITS PAID TO DATE \$	
		IF EMPLOYEE WAS PAID FULL SALARY FOR ANY PERIOD OF DISABILITY, CHECK THIS BOX. <input type="checkbox"/>	
11. NATURE OF DISABILITY			
12. EMPLOYEE'S SIGNATURE			
<b>DISABILITY PAYMENT</b>			
13. DATE ACCIDENT REPORTED TO EMPLOYER	14. DATE FIRST PAYMENT WAS MADE TO EMPLOYEE	15. FIRST DAY OF PERIOD COVERED BY PAYMENT	
<b>NOTICE OF TERMINATION OF COMPENSATION</b>			
<p>16. THIS IS TO NOTIFY THE <b>DIVISION OF WORKERS' COMPENSATION</b> AND THE EMPLOYEE THAT COMPENSATION PAYMENTS IN THE ABOVE MATTER HAVE TERMINATED, THE LAST PAYMENT HAVING BEEN MADE ON _____ 20____ FOR THE FOLLOWING REASONS _____</p> <p>_____</p> <p>_____</p>			
17. RETURN TO WORK DATE		18. PREPARED BY	
19. EMPLOYER'S OR INSURER'S SIGNATURE		20. DATE	21. PHONE NO.
<b>DEATH BENEFIT PAYMENT</b>			
22. TO WHOM PAID		23. WEEKLY AMOUNT PAID	