

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
 CONCORD, NH 03301

MEMO OF PERMANENT IMPAIRMENT AWARD

EMPLOYEE NAME	EMPLOYEE SOCIAL SECURITY NO.
EMPLOYER NAME	EMPLOYER FEDERAL IDENTIFICATION NO.
INSURANCE CARRIER NAME	CARRIER ADJUSTING OFFICE NO.
CARRIER ADDRESS	CARRIER TELEPHONE NO.

DATE OF INJURY	DATE OF RETURN TO WORK
AVERAGE WEEKLY WAGE AT TIME OF INJURY	INJURY DATE COMP. RATE

PRESENT EMPLOYER
ADDRESS

AWARD

PERCENTAGE OF PERMANENCY AND BODY PART
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SUBJECT TO REVIEW AND APPROVAL BY COMMISSIONER OF LABOR	PI WEEKLY COMP. RATE		ATTACH MEDICAL REPORT
	NO. OF WEEKS OF THE AWARD	TOTAL \$ AMOUNT OF AWARD	
	DATE OF PERMANENT IMPAIRMENT RATING		
	AWW AT FIRST PI EVALUATION		

DATE _____

SIGNATURE
TITLE

DEPARTMENT APPROVAL
