

Commonwealth of Massachusetts
Human Resources Division



Workers' Compensation Section
One Ashburton Place, 3rd Floor
Boston, MA 02108

CONCURRENT EMPLOYMENT REVIEW FORM

All injured workers should complete the Concurrent Employment Review Form. The employee must report all earnings and indicate if he/she will continue to work for another employer(s) (public or private) while the workers' compensation claim is being processed and throughout the course of his/her workers' compensation claim.

If the employee is working at the time of the state industrial accident, the salary from that job must be considered by the HRD adjuster when calculating the AWW and the Compensation rate. If the employee continues to work at his/her other employment, he/she would be paid section 35 benefits and not section 34 benefits.

Your review of concurrent employment is separate from the Earnings Report authorized under M.G.L. Chapter 152, s. 11D requiring the reporting of all earnings including wages or salaries earned from self-employment. The purpose of this review is to insure that the employee receives the appropriate compensation, which is based on the loss of **all earnings**. If the employee returns to any of his/her former employer(s), adjustments must be made to the compensation rate and the payment section.

In the event the injured worker states that he/she has no concurrent employment, that should be noted on the form and filed with the HRD Adjuster.

It is essential that the workers' compensation agent incorporate this review into the initial agency level claims investigation process. Please use the attached HRD "CONCURRENT EMPLOYMENT REVIEW FORM", when meeting with the injured worker when a claim is being filed.

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CONCURRENT EMPLOYMENT REVIEW FORM

CLAIMANT'S NAME: _____ SS# _____

STATE AGENCY: _____

DATE OF INJURY: _____

OTHER EMPLOYER NAME: (public or private) _____

EMPLOYER ADDRESS: _____

CONTACT PERSON: _____ Telephone # _____

DATES OF OTHER EMPLOYMENT: From _____ To _____

DO YOU EXPECT THIS EMPLOYMENT TO CONTINUE? Yes _____ No _____

JOB DESCRIPTION OF OTHER EMPLOYMENT: _____

Please list all positions both private and public other than the position for which you are claiming workers' compensation. Attach a separate sheet for each position.

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
35		
36		
37		
38		
39		
40		
41		
42		
43		
44		
45		
46		
47		
48		
49		
50		
51		
52		

I hereby certify that the above information is a complete and accurate statement of income from any other employment. Signed under the pains and penalties of perjury.

 Claimant's Signature

 Date

This statement of income is to be utilized to determine the amount of workers' compensation you may receive for the injury for which you have a claim.