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

SUBJECT TO REVIEW AND APPROVAL BY COMMISSIONER OF LABOR

PI WEEKLY COMP. RATE	
NO. OF WEEKS OF THE AWARD	TOTAL $ AMOUNT OF AWARD
DATE OF PERMANENT IMPAIRMENT RATING	
AWW AT FIRST PI EVALUATION	

ATTACH MEDICAL REPORT

DATE _____

SIGNATURE
TITLE

DEPARTMENT APPROVAL

10WCA (10/98)