TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Complete if known:

DWC claim #

Insurance carrier claim #

Employee's multiple employment wage statement

Section 1: Injured employee information

1. Name (first, middle, last)	**2. Social Security number** (last four digits) XXX-XX-
3. Address (street or PO Box, city, state, ZIP code)	**4. Phone number**
5. Date of injury (mm/dd/yyyy)	**6. Date of hire** (mm/dd/yyyy)
7. First day of missed work (mm/dd/yyyy)	**8. Returned to work on** (mm/dd/yyyy) ☐ **Has not returned to work**
9. Was the injured employee working for the non-claim employer on the date of injury? ☐ Yes ☐ No	

Section 2: Non-claim employer information

10. Name	**11. Address** (street or PO box, city, state, ZIP code)
12. Phone number	**13. Federal tax ID number**
14. Printed name (person submitting form)	**15. Job title** (person submitting form)

Section 3: Wage information

16. The wage information on this form is for ☐ the injured employee **or** ☐ a similar employee.

17. Salary amount (if applicable)	**18. Hourly rate** (if applicable)	**19. Daily pay** (if applicable)	**20. Other** (if applicable)
$	**$**	**$**	**$**
21. Wages were paid: ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly**			

Week	22. Number of hours worked	23. Pay period dates (mm/dd/yyyy-mm/dd/yyyy)	24. Gross wage amount
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
		25. Total gross wages	

26. Certify with your signature.

I certify the information provided in this form is true and correct.

Signature_____ **Date**_____

FAQ

Employee's multiple employment wage statement

Who is responsible for the DWC Form-003ME, *Employee's Multiple Employment Wage Statement*?
An injured employee that has more than one job at the time of their injury is responsible for filing a completed DWC Form-003ME with their insurance carrier and Texas Department of Insurance, Division of Workers' Compensation (DWC). The injured employee should have each non-claim employer complete the form.

Where do I send this form?
Once completed, the injured employee must send a copy to the insurance carrier **and** to DWC:

- **Fax:** 512-804-4378
- **Mail:** Texas Department of Insurance, Division of Workers' Compensation
  Claims and Customer Services, Mail Code CCS
  PO Box 12050
  Austin, TX 78711-2050

What is a non-claim employer?
This is an employer other than the claim employer by whom the employee was employed at the time of the on-the-job injury (28 Texas Administrative Code (TAC) Section 122.5(a)(2)).

How do I report wages?
Report only wages that are reported for federal taxes **paid in the 13 weeks before the date of injury** according to the employee's pay period. Employers may report 14 weeks if paid biweekly or three months if paid monthly. In all cases, list the dates that each period covers.

- If the employee was **not employed for 13 weeks** before their injury, report wages of an employee who has the training, experience, skills, same pay, and same number of hours (28 TAC Section 122.5(e)(2)).
- If **no similar employee exists**, report all wages the injured employee earned before the injury.

What is average weekly wage?
The gross average amount of money the employer paid the injured employee each week in the 13 weeks before the injury or illness.

Questions?
Call 1-800-252-7031, Monday to Friday, 8 a.m. to 5 p.m., Central time. Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.