

THE STATE OF NEW HAMPSHIRE  
**DEPARTMENT OF LABOR**  
 CONCORD, N.H. 03301

**MEMO OF PAYMENT OF  
 DISABILITY COMPENSATION**

You are required to pay total disability compensation and to file, with the department, copy to employee, memorandum of payment in accordance with RSA 281-A:40, 41 and 42 **as soon as possible after date of knowledge of disability of four or more days, but no later than seven days thereafter.** Filing shall also be made upon making provisional payment, upon adjusting such payment, upon making last payment, and upon making payment resulting from departmental hearing. **Failure to pay and to file memorandum promptly, in the absence of a legitimate denial of benefit, shall render a carrier liable to a civil penalty of up to \$2,500.**

Employee \_\_\_\_\_ (Name) \_\_\_\_\_ (Soc. Sec. No.)  
 Employer \_\_\_\_\_ (Name) \_\_\_\_\_ (Federal Identification No.)  
 Carrier \_\_\_\_\_ (Name) \_\_\_\_\_ (Carrier Number Assigned by DOL)

Date of:	Injury	Disability/Recurrence*	First or Sup. Rep. R'cd	First Payment	Last Payment

\*Recurrence refers to subsequent periods of disability

1

Compensation at the rate of \$ \_\_\_\_\_ per week  
 Beginning \_\_\_\_\_ Avg. Wkly. Wage of \$ \_\_\_\_\_  
**Check box if compensation payment results from department hearing decision**   
**Check box if memo indicating provisional payment already filed**   
**Check box if memo indicating adjustment in total disability - RSA 281-A:29**   
**SEE ATTACHED WAGE SCHEDULE, EXCEPT IF DISABILITY OF LESS THAN FOURTEEN DAYS**

2

Missing Wage Schedule  
 When Expected \_\_\_\_\_  
 Provisional Payment of \$ \_\_\_\_\_ Subject to Later Adjustment

3

Total Compensation Paid \$ \_\_\_\_\_ Ending Date \_\_\_\_\_  
 Date of Return to Work \_\_\_\_\_ Earning after R.T.W. \_\_\_\_\_  
 Name of Employer (New or same) \_\_\_\_\_

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Signature)

Dept. Approval