

**South Dakota Department of Labor  
Division of Labor and Management**

**CALCULATION OF COMPENSATION**

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Employee: \_\_\_\_\_ Social Security No: \_\_\_\_\_  
Employer: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Insurer: \_\_\_\_\_ Insurance Claim No: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone No: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

The rate of compensation has been calculated for said injury sustained by the employee based upon the following information.

Date of Injury: \_\_\_\_\_  
Date Disability Began: \_\_\_\_\_  
Gross Average Weekly Wage: \$ \_\_\_\_\_

If on commission, or explanation is necessary, please explain how the average weekly wage was calculated. If available, please attach a wage statement.

\_\_\_\_\_  
\_\_\_\_\_

Compensation shall be paid at the rate of \$ \_\_\_\_\_ per week,  
to be paid (please indicate one) WEEKLY; BIWEEKLY; OTHER \_\_\_\_\_  
from the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, until terminated in accordance with the  
provisions of the Workers' Compensation Laws of the State of South Dakota.  
(Month) (Year)

This document does not constitute an agreement, stipulation, or release. This document does not affect the employee's right to seek benefits, including a change in the rate of compensation, nor does it restrict the employer/insurer's right to deny any claim. This form is meant to lead to an understanding between the parties regarding the rate of compensation. No party is required to sign this form in order to make payments or receive payment of benefits.

Employee: \_\_\_\_\_ Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Date: \_\_\_\_\_  
Insurance Adjuster: \_\_\_\_\_ Date: \_\_\_\_\_

Submit form to: South Dakota Department of Labor  
Division of Labor and Management  
700 Governors Drive  
Pierre, SD 57501-2291  
Telephone (605)773-3681