SD EForm - 0809 V1

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HELP

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION
DIVISION OF LABOR AND MANAGEMENT
Tel: 605.773.3681 dlr.sd.gov

MEMORANDUM OF PAYMENT FOR PERMANENT PARTIAL DISABILITY

Claim Administrator Information:

Claim Administrator Federal ID No _____ **Carrier Code** _____ **Claim #** _____

Name (DBA) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Telephone Number _____ **Form Completed By** _____

Employer Information:

Employer Federal ID No _____ **Employer Name (DBA)** _____

Employee/Injury Information:

Employee/Claimant SSN _____ **Date of Injury** _____

Body Part(s) Injured _____ _____ _____ _____

Employee/Claimant Name _____ _____ _____
(Last) (First) (MI)

Compensation Information:

Gross Average Weekly Wage _____

Claimant's compensation rate is _____

Compensation to be paid to the employee for permanent physical impairment pursuant to SDCL 62-4-6 ( )

is _____.

If the employee's percent of physical impairment increases as a result of such work-related injury in the future, the employer/insurer may be responsible to pay the employee such additional compensation as is medically determined to be applicable.

If additional medical treatment is required in the future as a result of such injury, the employer/insurer may be obligated to pay such future medical expenses.

This memorandum is a receipt only. It does not constitute an agreement, stipulation or release. The Division of Labor and Management retains jurisdiction as to all issues. The employee does not waive his/her right to pursue any benefits to which he/she may be entitled.

Claimant/Employee Signature _____ **Date** _____

Claim Administrator Signature _____ **Date** _____

Division of Labor and Management Approval by: _____ **Date** _____

A doctor's impairment rating must be submitted with the Form 111 to the Division of Labor and Management.

DLR-LM-111Revised 02/06/2017

PRINT FOR MAILING CLEAR FORM

Completed and signed form should be mailed to the insurance company