Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

Interim Status Report

Reset

IS 03

DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	
INSURER CLAIM NUMBER	

THE FORM MUST BE SUBMITTED ANNUALLY ON ALL CLAIMS OF CONTINUING DISABILITY, SUPPLEMENTARY OR DEPENDENCY BENEFITS. Please provide additional information on the Benefit Addendum (BA01).

☐ **Temporary Total*** ☐ **Permanent Total***

	FROM	THROUGH	WEEKS	RATE	*TOTAL
Balance Carried Forward					
				TOTAL:	

Temporary Partial

	FROM	THROUGH	WEEKS	RATE	*TOTAL
Balance Carried Forward					
				TOTAL:	

Permanent Partial

Permanent Partial Disability _____%

☐ Injuries on or after 10/01/95

☐ Impairment Compensation (injuries 01/01/1984 - 09/30/1995)

☐ Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)

☐ _____ [part of body] (injuries before 01/01/1984)

	TOTAL:	

*These areas need not be completed if this form is being attached to and filed with the **Annual Claim for Reimbursement of Supplementary Benefits.**

		FROM	THROUGH	WEEKS	RATE	TOTAL
Retraining Benefits	**Balance Carried Forward**					
					TOTAL:	
Dependency Benefits	**Balance Carried Forward**					
					TOTAL:	
Supplementary Benefits*	**Balance Carried Forward**					
					TOTAL:	

Social Security Benefits or Other Government Benefits* ☐ Retirement ☐ Disability

Name of Program: _____

FROM	THROUGH	PER WEEK

*These areas need not be completed if this form is being attached to and filed with the **Annual Claim for Reimbursement of Supplementary Benefits.**

Attorney Fees Paid		Interest Paid	
Attorney Fees Still Withheld		Lump Sum Payment Under Award or Order	
Attorney Fees Reimbursed to Employee M.S. 176.081, subd. 7		Total Compensation Paid to Employee	
		Total Dependency Benefits Paid (Please attached copy of worksheet)	
INSURER/SELF-INSURER/TPA		CLAIM REPRESENTATIVE NAME	
ADDRESS		PHONE NUMBER (include area code)	
CITY STATE ZIP CODE		DATE SERVED	

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.