OWC FILE NO. _____

CARRIER FILE NO. _____

STATE OF DELAWARE

OFFICE OF WORKERS' COMPENSATION

RECEIPT OF COMPENSATION PAID

DATE _____

Received of _____
(Insurance Carrier/Self-Insurer/Third Party Adjuster)

the sum of $ _____, making in all the total sum of $ _____

in settlement of compensation due for the _____ of
(type)

_____ which began
(Employee Name)

on _____, and terminated on _____.
(date) (date)

_____
Employee Signature

_____
Address

_____

Your signature on this receipt will terminate your rights to receive the worker's compensation benefits specified above on the date indicated. This form is not a release of the employer's or the insurance carrier's workers' compensation liability. It is merely a receipt of compensation paid. The claimant has the right within five years after the date of the last payment to petition the Office of Workers' Compensation for additional benefits.

Revised 1/18/2023