

WORKER'S COMPENSATION TIME MISSED/RETURN TO WORK NOTIFICATION

Employee Name _____

Department _____

Claim Number (to be completed by HR) _____

Date of Injury _____

SECTION I – MISSING WORK

Complete Section I when an employee **begins missing work** due to a work related injury or illness. Enter the date the employee began missing full work days and check reason #1 or #2 as appropriate.

Employee began missing work (full days) on _____. (Attach original physician's excuse for all time missed due to work related injury/illness).

#1 Employee is excused from work by his/her physician.

#2 Employee is released to light duty but the department is unable to accommodate his/her restriction(s).

Note: Supervisor must provide, in writing, detailed business related reasons if unable to accommodate job modifications and/or work restrictions. Rationale must be based on essential work tasks and responsibilities as listed in the employee job description in relation to the job modifications/restrictions directed by the treating physician.

Reasons:

SECTION II – RETURN TO WORK

Complete Section II when an employee returns to work on light or full duty from a work related injury/illness.

Employee returned to light duty work on _____.

(Attach the original release from panel/treating physician. Supervisor has reviewed the work restrictions with the employee and the employee understands his/her responsibility to adhere to established job modifications.)

Employee returned to full duty with no restriction(s) on _____.

(Attached the original release from physician to return to full duty).

Supervisor Signature

Date