Revised 03/09

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 _____
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 respons