DOCUMENTATION FOR TIME LOST FROM WORK DUE TO WORKERS' COMPENSATION RELATED ABSENCE

This form is to be completed and submitted for all excused absences from work that are related to a workers' compensation injury/case. The employee must notify the supervisor as soon as he/she is aware of any potential for lost work time or change in schedule.

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME: ________________________________ DATE OF LOST TIME: __________________

REASON (Check one):
☐ Office Visit ☐ Treatment / Surgery ☐ Independent Medical Evaluation
☐ Physical Therapy ☐ Workers' Compensation Hearing ☐ Other

TIME LEFT WORK: ____________ TIME RETURNED TO WORK: ____________ _____ DID NOT RETURN TO WORK
DOCTOR/ MEDICAL PROVIDER / PLACE VISITED: ____
ADDRESS: ______________________________________ CITY/STATE/ZIP: __________________________

TO BE COMPLETED BY MEDICAL PROVIDER (include wait time)

TIME IN: ______________ TIME OUT: ______________
PROVIDERS NAME: ____
PROVIDER SIGNATURE: ____

REASON (Check one):
☐ Office Visit ☐ Treatment / Surgery ☐ Independent Medical Evaluation
☐ Physical Therapy ☐ Workers' Compensation Hearing ☐ Other

TIME LEFT WORK: ____________ TIME RETURNED TO WORK: ____________ _____ DID NOT RETURN TO WORK
DOCTOR/ MEDICAL PROVIDER / PLACE VISITED: ____
ADDRESS: ______________________________________ CITY/STATE/ZIP: __________________________

TO BE COMPLETED BY MEDICAL PROVIDER (include wait time)

TIME IN: ______________ TIME OUT: ______________
PROVIDERS NAME: ____
PROVIDER SIGNATURE: ____

REASON (Check one):
☐ Office Visit ☐ Treatment / Surgery ☐ Independent Medical Evaluation
☐ Physical Therapy ☐ Workers' Compensation Hearing ☐ Other

TIME LEFT WORK: ____________ TIME RETURNED TO WORK: ____________ _____ DID NOT RETURN TO WORK
DOCTOR/ MEDICAL PROVIDER / PLACE VISITED: ____
ADDRESS: ______________________________________ CITY/STATE/ZIP: __________________________

TO BE COMPLETED BY MEDICAL PROVIDER (include wait time)

TIME IN: ______________ TIME OUT: ______________
PROVIDERS NAME: ____
PROVIDER SIGNATURE: ____

Send, fax or email completed form to: ____

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