WORKERS' COMPENSATION
LOST TIME AND RETURN TO WORK FORM

TO: **PERSONNEL CABINET**
Return-to-Work Program
501 High Street, 3rd Floor
Frankfort, KY 40601
502/564-0348
FAX: 502-696-5228

CONTACT NAME: _____

AGENCY: _____

PHONE NUMBER: _____

DATE: _____

This form must be completed by the supervisor and submitted immediately when one of the following occurs:

1. When an employee begins to lose a full day from work due to a work-related injury or illness.
2. When an employee returns to modified duty OR full duty work (This information is important in order to assure that no overpayment of wage benefits occur).
3. At the time of death of an employee.

Name of Work Related Injured or Ill Employee: _____
(FIRST) (MI) (LAST)

Date of Work Related Injury or Illness: _____

Date Loss of Work Began: _____

Date Employee Returned to Modified Duty Work: _____

Date Employee Returned to Full Duty Work: _____

Comments: (Notify if death of employee, employee returned to work with restrictions, employee returned to only part-time work, employee returned at different job, etc.)

Completed by: _____ **Official Title:** _____