

MEMORANDUM

TO: PERSONNEL CABINET
Return-To-Work Program
Room 511, 200 Fair Oaks Lane
Frankfort, Kentucky 40601
502-564-0348
(FAX) 502-564-3524

CONTACT NAME: _____
AGENCY: _____
PHONE NUMBER: _____

SUBJECT: Lost Time and Return to Work Form

DATE: _____

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

- 1) When an injured employee begins to lose a full day from work due to a work-related injury.
- 2) When an injured employee returns to modified duty OR full duty work. (This information is important in order to assure that an employee is not over paid.)
- 3) At the time of death of an injured employee.

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NAME OF INJURED _____
(FIRST) (MI) (LAST)

DATE OF INJURY _____

DATE LOSS OF WORK BEGAN _____

DATE INJURED RETURNED TO MODIFIED DUTY WORK _____

DATE INJURED RETURNED TO FULL DUTY WORK _____

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

COMPLETED BY: _____ **OFFICAL TITLE** _____