

Colorado Workers' Compensation Supplemental Report of Return To Work

Workers' Compensation (WC) # _____ Date of Injury _____
Employee Name _____ Carrier Claim # _____
Social Security # _____ Employer _____

Purpose:

The purpose of this form is to provide information to determine the accurate payment of temporary disability benefits.

Instructions:

- 1. This form may be completed by the employee or employer.**
- 2. This form should be completed each time the employee returns to work at full or reduced wages.**
- 3. This form should be forwarded to your workers' compensation carrier.**

1. Last day employee worked _____

2. Date employee returned to work _____

3. Employee's return-to-work-wages (Check the box that applies)

- Full Wages
 Reduced Wages (Provide wage information to the claims adjuster every 2 weeks during periods of wage loss)

Additional Information _____

Completed by (Check the box that applies) Employee Employer

Name Date

Address _____

Phone # () _____

Fax # () _____