TOWN OF MANCHESTER, CONNECTICUT
WORKERS' COMPENSATION – LOST TIME REPORT

Please complete this form when an employee returns to work from a work related accident/illness/injury. Keep a copy for your records and send a copy to Jan Devendorf in the Human Resources Department. Attach the doctor's note releasing employee to return to work.

Employee's Name: _____

Employee's Position: _____

Department/Division: _____

Date of Accident: _____

First Day Out: _____

Date returned to work: _____

Total number of <u>scheduled</u> work days missed: _____

Comments: _____

_____

_____

_____

_____ _____

(Supervisor's Signature) (Date)