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 / Full Hours

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

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Additional Information ____________

Completed by (Check the box that applies) Employee Employer

____________ Name ____________ Date

Address ____________

Phone # ____________

Fax # ____________

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