Go to Form

Instructions for Completing the

Supplemental Report of Accident

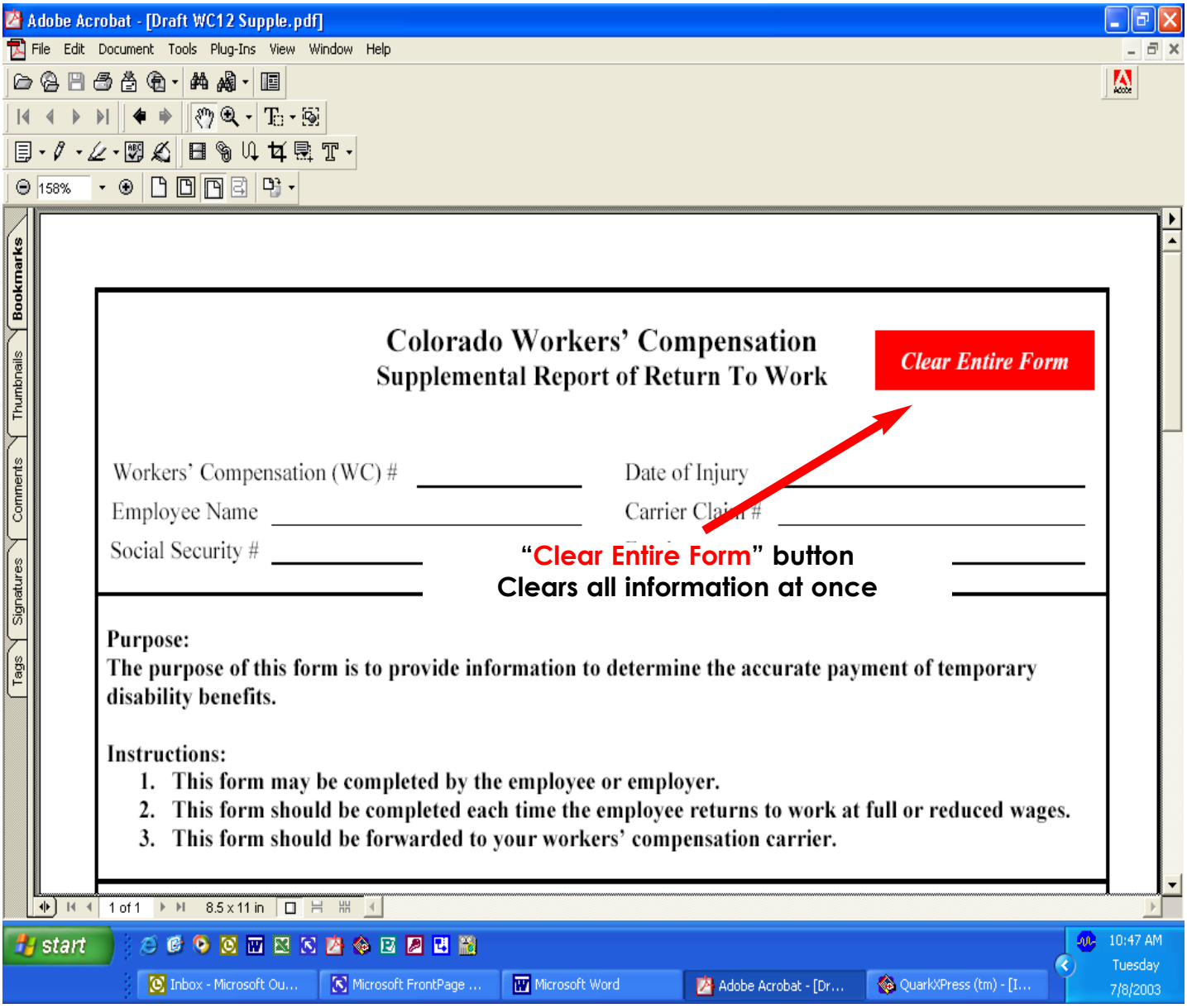
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "W.C. No." box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for Social Security #, phone # and fax #. Do not use dashes; when you tab out of the field, it will fill in automatically. To fill in a check box, click inside the box with your mouse.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.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Colorado Workers' Compensation
Supplemental Report of Return To Work
Clear Entire Form
Workers' Compensation (WC) #
Date of Injury
Employee Name
Carrier Claim #
Social Security #
"Clear Entire Form" button
Clears all information at once
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.
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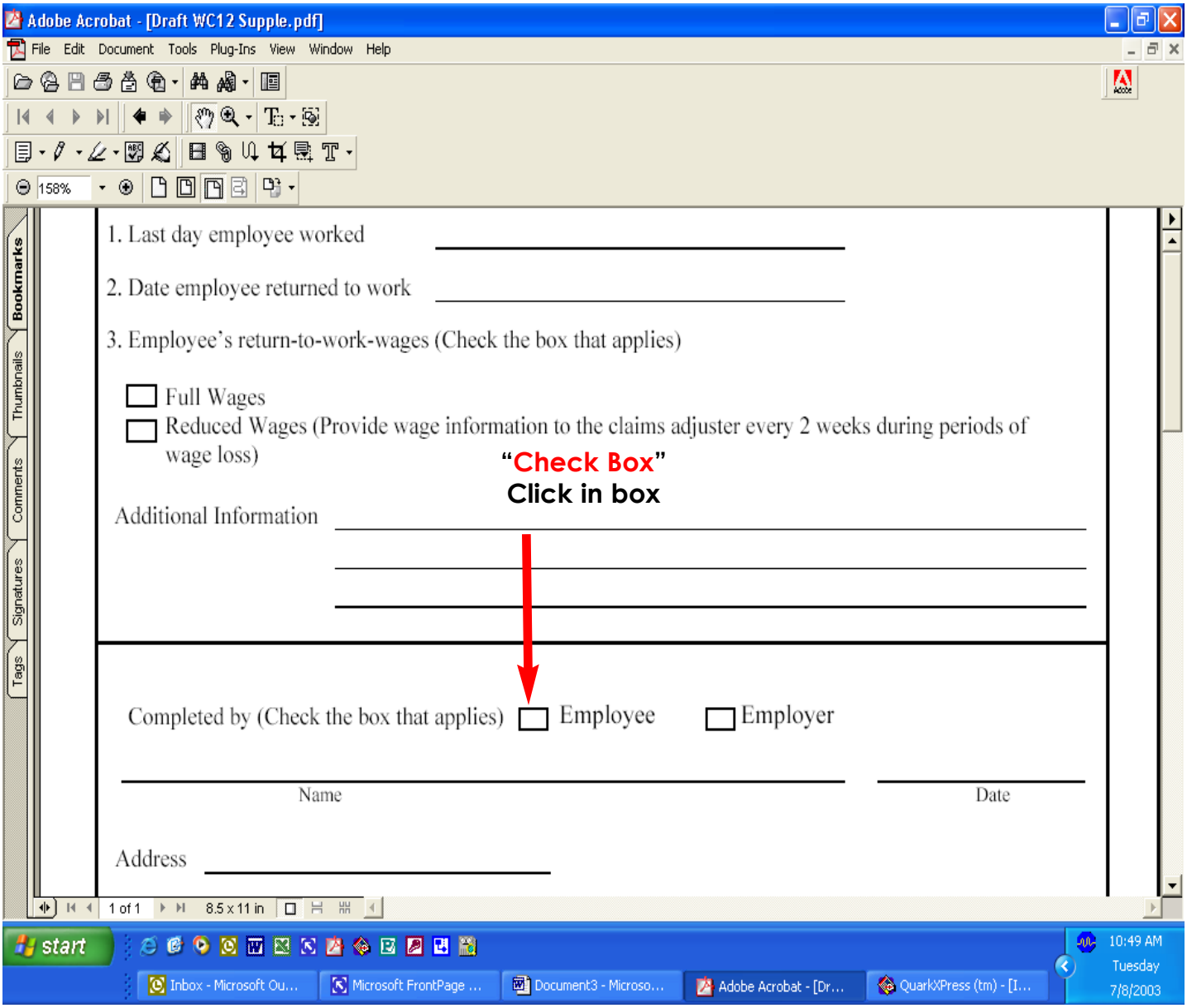
7/8/2003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1. Last day employee worked
2. Date employee returned to work
3. Employee's return-to-work-wages (Check the box that applies)
Full Wages
Reduced Wages (Provide wage information to the claims adjuster every 2 weeks during periods of wage loss)
"Check Box"
Click in box
Additional Information
Completed by (Check the box that applies) Employee Employer
Name
Date
Address
1 of 1
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Tuesday
7/8/2003

Back to Instructions

Colorado Workers' Compensation
Supplemental Report of Return To Work

Clear Entire Form

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 # _____