WORKERS' COMPENSATION
LOST TIME AND RETURN TO WORK FORM
WCF-1

TO: **PERSONNEL CABINET**
Return-to-Work Program
501 High Street, 3rd Floor
Frankfort, KY 40601
502-564-0348
FAX: 502-696-5228

CONTACT NAME: _____

AGENCY: _____

PHONE NUMBER: _____

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 employee begins to lose a full day from work due to a work-related injury or illness.
2. When an employee returns to modified duty OR full duty work (This information is important in order to assure that no overpayment of wage benefits occur).
3. At the time of death of an employee.

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Name of Work Related Injured or Ill Employee: _____
(FIRST) (MI) (LAST)

Date of Work Related Injury or Illness: _____

Date Loss of Work Began: _____

Date Employee Returned to Modified Duty Work: _____

Date Employee Returned to Full Duty Work: _____

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

_____

Completed by: _____ **Official Title:** _____

WORKERS' COMPENSATION
REQUEST TO USE ACCUMULATED LEAVE
WCF-2

Name: _____ PERNR: _____

Date of Injury or Illness: _____

Pursuant to 101 KAR 2:140, Section 4(2), I hereby request payment from my accumulated leave balances while I am off work due to an illness or injury for which workers' compensation income benefits are claimed.

I acknowledge that I am not entitled to use accumulated leave for time off from work due to an illness or an injury for which workers' compensation income benefits are claimed except to supplement my workers' compensation income benefits and maintain my regular full salary.

I hereby remit my workers' compensation income benefits to the following State Agency:

_____

I authorize agency to utilize workers' compensation income benefits to restore a portion of the accumulated leave time to maintain my full salary. I understand that no accumulated leave will be restored until I endorse and return the workers' compensation income benefit check to the agency.

At the time the agency receives the endorsed check, the appropriate amount of leave will be restored. If I do not endorse and return the income benefit check to my agency, I authorize my employing agency to deduct from my pay a sum equal to any amount of workers' compensation income benefits I fail to remit to my agency pursuant to this agreement.

I may revoke this authority at any time in writing by delivering a copy of the writing to the agency; however, the revocation shall not apply to any workers' compensation income benefits check for periods of time in which I have already received paid leave.

Signed this the day of , 20 .

_____
Signature

_____
Witness