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 # ( ) _____

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