WORKERS' COMPENSATION VERIFICATION OF EMPLOYEE'S LOST TIME DUE TO WORK-RELATED INJURY

To: Risk Management / Workman's Compensation Office
Fax Weekly to: 301-952-6027

_____
(Date)

From: _____ _____
(School/Work-Site) (Pay Location)

Employee's Name: _____ SS #: _____

Date of Injury: _____ EIN #: _____

(NOTE: Administrative Procedure 4146.1 states an employee will not be charged leave on the date of injury)

Occupation: _____

First Day Out: _____ Contract Hours Per Week: _____
(Date)

Verify below all days (including 1/2 days) missed from work (to date) due to injury and the type of leave actually charged. If employee has exhausted all leave, charge employee Leave Without Pay. Submit Weekly.

Date(s)	Total No. of Days	Type of Leave
_____	_____	Sick Leave
_____	_____	Annual Leave
_____	_____	Personal Leave
_____	_____	Leave Without Pay

Date Returned to Work: _____

_____
Signature of Leave Granting Authority
(Principal/Dept. Head/Supervisor/Foreman)

cc: Employee
Worksite

Please Do Not Write Below This Line