



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: _____
(Date)

Contract Hours Per Week: _____

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.

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

Date Returned to Work: _____

cc: Employee
Worksite

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

Please Do Not Write Below This Line