

EMPLOYEE'S RETURN TO WORK REPORT

STATE OF MAINE

WORKERS' COMPENSATION BOARD

STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:		
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:	
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER/INSURER

THIS REPORT IS SENT TO THE EMPLOYEE WHEN FILING THE MEMORANDUM OF PAYMENT PURSUANT TO 39-A M.R.S.A. § 205 (7).

19.

NOTICE TO EMPLOYEE

IF YOU RETURN TO WORK WITH A NEW EMPLOYER, COMPLETE BOX 20 AND RETURN THIS REPORT TO THE BOARD ADDRESS LISTED ABOVE, THE EMPLOYER LISTED IN BOX 2 AND THE INSURER LISTED IN BOX 4 WITHIN 7 DAYS PURSUANT TO 39-A M.R.S.A. §308 (1).

FAILURE TO COMPLETE AND RETURN THIS REPORT MAY RESULT IN THE DISCONTINUANCE OF YOUR WORKERS' COMPENSATION BENEFITS.

PART 2 (COMPLETED BY THE EMPLOYEE)

20.

COMPLETE THE FOLLOWING INFORMATION (USE REVERSE SIDE IF NECESSARY).

A. NEW EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

B. DATE OF HIRE: _____

C. ATTACH VERIFICATION OF INCOME OR LIST ANTICIPATED INCOME:

D. COMMENTS:

20. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

EMPLOYEE SIGNATURE

DATE