COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF 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 / Full Hours

☐ Reduced Wages (Provide wage information to the claims adjuster every 2 weeks during periods of wage loss)

☐ Full Wages / Reduced Hours (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 # _____