I.C. Form 14

File No.

ORIGINAL
Mail to
Surety

Employer's Supplemental Report

Employer: Fill out this form in duplicate. Mail copy to Industrial Commission (P.O. Box 83720, Boise, Idaho 83720-0041) and the original to your workers' compensation insurer at the following times:

1. Upon termination of disability (regardless of length of time disabled for work).
2. At the end of 60 days from the date disability began if employee is disabled that long.

Any employer who fails to make this report upon termination of the disability of one of his insured employees and (if the disability extends beyond a period of 60 days) at the end of that period is subject to a penalty not to exceed $500.00.

<table>
<tr><td>Name of injured employee:</td><td>Address where mail should be sent:</td></tr>
<tr><td>Date of injury:</td><td>Date disability began:</td></tr>
<tr><td>Were wages paid for the day the disability began?
☐ Yes ☐ No</td><td>What wages, if any, have been paid during the period of disability?</td></tr>
<tr><td rowspan="2">Has the injured employee returned to work?
☐ Yes ☐ No</td><td>If so, on what date was he re-employed?</td></tr>
<tr><td>At what daily wage?</td></tr>
<tr><td>At light or regular work?
☐ Light duty ☐ Regular work</td><td>If re-employed at less wages than received before the injury, give reason:</td></tr>
<tr><td colspan="2">Give date the injured employee recovered sufficiently to return to regular work:</td></tr>
</table>

THE ABOVE STATEMENTS ARE CORRECT
(The employee MUST NOT sign this form BEFORE the work disability ceases)

_____
Employer

_____
Signature of injured employee

_____
Signature of Authorized Agent

Date of this report _____

Address _____