Town of Washington
Lost Time Report

Employee Name: _____

_____Date of first full date lost from work: _____

_____Return to work date: _____

If you have a reduction in hours due to WC:

_____ Reduced hours start date: _____

_____ Reduced hours end date: _____

_____ I have officially returned to work on _____

_____ _____
Employee Signature Date

*This form is required each time you have a change in payroll status due to a Workers Comp injury.

Medical proof must be submitted with this form.