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.