



TIME-LOSS NOTIFICATION

Unit	Work Position
Claim Number	
Date of Request	
Date of Injury	

Worker instructions: This is your request for time-loss compensation, which must be completed by you AND your doctor before we can consider you for benefits. If you are unable to work due to your workplace injury AND your employer is not paying your wages:

- 1.) Fill in your section of the form, sign and date.
- 2.) Take it to your doctor to complete.

Doctor instructions: After completing this form, please sign and mail to the above address.

Worker's Statement

I have not worked, nor was I able to work, due to this work-related injury/illness from _____ to _____
 (This means you did not perform **any** type of work – paid or unpaid – such as volunteer work, self-employment, COPES or CHORE Services.)

I will/did return to work on _____	I am now working _____ Hours/Day	I am now working _____ Days/Week	My current wage is: \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month
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I have applied for the following benefits: None Unemployment Food stamps only Other public assistance programs Social Security benefits

On the date of your injury, was your employer paying any part of your and/or your family's medical, dental and/or vision insurance benefits, or providing housing, board and/or fuel (utilities)? Yes No

Are you still receiving these benefits? Yes No Date coverage ended _____

By signing below, I am certifying the following: I understand that if I make a false statement about my activities or physical condition, I will be required to refund my benefits and I may face civil or criminal penalties. I understand I must immediately contact my claim manager if I perform any work (paid or unpaid), if my doctor releases me for work, if I am incarcerated, or if the custody of my children changes.

Phone #	Date	Worker's signature
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Doctor's Statement

Diagnosis due to workplace injury or illness:

I certify this patient, because of the above condition, has been unable to perform any type of work activity – paid or unpaid – from _____ to _____

This patient is released for work on: _____ -OR- I expect to release this patient to return to work on: _____

List the objective medical findings that show this patient is unable to work because of this work-related condition:

Please list your *specific restrictions* for this patient, due to this injury:

Are these restrictions: <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> Undetermined	Has the patient's condition(s) due to this injury reached maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined
Will permanent impairment result from this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined	

Remarks

Physician's name (print or type)	Provider account #	Phone #
Address	City	State ZIP+4
Date	Physician's signature	