EMPLOYEE'S RETURN TO WORK REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

PART I (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER/INSURER

THE EMPLOYER/INSURER SHALL SEND THE EMPLOYEE'S RETURN TO WORK REPORT TO THE EMPLOYEE WHEN FILING THE MEMORANDUM OF PAYMENT PURSUANT TO 90 MAR 351 CH. 8. §17.

19.

NOTICE TO EMPLOYEE

IF YOU RETURN TO WORK WITH A NEW EMPLOYER, COMPLETE BOXES 20 AND 21 AND FILE COPIES OF THIS REPORT WITH THE BOARD AND YOUR PREVIOUS EMPLOYER AT THE ADDRESSES LISTED ABOVE WIITHIN 7 DAYS PURSUANT TO 39-A M.R.S.A. §308(1).

FAILURE TO COMPLETE AND RETURN THIS REPORT MAY AFFECT YOUR WORKERS' COMPENSATION INDEMNITY BENEFITS.

PART II (COMPLETED BY THE EMPLOYEE)

20. COMPLETE THE FOLLOWING INFORMATION (USE REVERSE SIDE IF NECESSARY).

A. NEW EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

B. DATE OF HIRE: _____

C. ATTACH VERIFICATION OF INCOME OR LIST ANTICIPATED INCOME: _____

_____

D. COMMENTS:

21. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

_____ _____
EMPLOYEE SIGNATURE DATE

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

WCB-231 (eff. 1/1/13)