EMPLOYEE'S RETURN TO WORK REPORT

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

PART 1 (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER 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

THIS REPORT IS SENT TO THE EMPLOYEE WITH THE 21-DAY CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION OR THE PETITION FOR REVIEW PURSUANT TO RULE 8.15.

19.

NOTICE TO EMPLOYEE

YOUR WEEKLY BENEFITS WILL BE REDUCED OR DISCONTINUED EACH WEEK TO THE AMOUNT SHOWN ON THE CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION OR PETITION FOR REVIEW. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION TO THE INSURER OF YOUR WEEKLY EARNINGS FOR THE 21-DAY PERIOD OR WHILE THE PETITION FOR REVIEW IS PENDING BEFORE THE WORKERS' COMPENSATION BOARD BY COMPLETING THE INFORMATION IN BOX 20 BELOW. IF YOU FAIL TO PROVIDE DOCUMENTATION, THE REDUCTION SHOWN ON THE CERTIFICATE OF DISCONTINANCE OR REDUCTION OR PETITION FOR REVIEW SHALL REMAIN IN EFFECT AND YOUR BENEFITS WILL NOT BE ADJUSTED.

PART 2 (COMPLETED BY THE EMPLOYEE)

20. **COMPLETE THE FOLLOWING INFORMATION.**

A. INCOME FROM NEW EMPLOYMENT (attach verification):

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

B. COMMENTS:

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

_____ _____
EMPLOYEE SIGNATURE DATE