

**NOTE: Please FAX this form to Catherine Rackliffe, UMD
Workers' Compensation Coordinator at 726-7505.
She will process and FAX it to Sedgwick.**

Sedgwick

Sedgwick Claims Management Services, Inc.
P.O. Box 46999, Eden Prairie, Minnesota 55344-9447
Telephone 612-826-3800. Facsimile 952-826-3785
Toll Free Telephone 1-800-231-0165

Date : _____
From: Employing Department
To : Sedgwick
Re : Work Comp Time Loss Report

RE : EMPLOYEE : _____
DATE OF INJURY : _____
SSN : _____
FILE NO. : _____

1. Please report all time lost from work (both ongoing and periodic), due ONLY to the above noted work-related injury to the above address, or fax to 952-826-3785. Please do not report any personal sick or vacation time paid not related to this injury.
2. Please report all part-time and full-time return to work, as well as the employee's *current* hourly wage. Please submit this report for each pay period in which the time loss occurs.
3. Please ensure all medical statements provided by the employee relating to this injury, and time loss, are attached and forwarded to Sedgwick.

* * * * *

1. Pay period ending: _____ Current hourly wage: \$ _____

<u>WEEK 1</u>			<u>WEEK 2</u>		
DATE	HOURS WORKED	HOURS LOST	DATE	HOURS WORKED	HOURS LOST
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

2. Part-time return to work on _____ at _____ hours per day at \$ _____ hourly wage.
Full-time return to work on _____ at \$ _____ hourly wage.

(Return to work dates not reported to Sedgwick immediately and accurately will result in an over payment of Workers' Compensation benefits to the employee, which is difficult to recover for the University of Minnesota.)

Department Signature: _____ Date: _____
Telephone: _____