Lost Time and Return to Work Form  
(WCF-1 Form)

DEPT. CONTACT NAME: ________________________________

DEPT.: ______________________________________________

PHONE NUMBER: ______________________________________

DATE: ________________________________________________

This form must be completed by the supervisor and submitted immediately when one of the following occurs:

1) When an injured employee begins to lose a full day from work due to a work-related injury.
2) When an injured employee returns to modified duty/light duty or full duty work (This information is important in order to assure that an employee is not over paid.)
3) At the time of death of an injured employee.

NAME OF INJURED: _______________________________________

(FIRST) (MI) (LAST)

DATE OF INJURY: _________________________________________

DATE INJURED RETURNED TO MODIFIED/LIGHT DUTY WORK: ____ _____________________________

DATE INJURED RETURNED TO FULL DUTY WORK: ________________________________

COMMENTS: (Notify if death of employee, Employee returned to work with restrictions, returned to only part-time work, etc.

COMPLETED BY: _______________________________ OFFICIAL TITLE: _________________________________

WCF-1 FORM