Form 110

RELEASE TO RETURN TO WORK

PLEASE PRINT OR TYPE

Instructions: This form must be submitted when an injured workers' temporary disability compensation is less than 90 days. The form must be completed by the adjustor after receiving a physician notification of release to return to full or light duty. The form must be submitted to the reemployment office within five (5) days of the release date.

General Information

Worker Name _____ Injury Date _____
Address _____ Employer _____
Phone Number _____SS# _____ Actual # of Lost Work Days _____

Released to Regular Duty	**Released to Light Duty**
Date _____	Date _____
Permanent Impairments, if any:	Permanent Impairments, if any:
_____	_____
_____	_____
_____	_____
	Anticipated Date of Release to Regular Duty: _____

Name of Person Submitting Form _____

Carrier Name _____

Phone Number _____ Date Submitted _____

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