



**Instructions**

Return this completed form to Human Resource Management. A copy of this completed form must be provided to your supervisor.

Fax: (860)706-5092 Attention: Workers' Compensation Unit or  
scan and e-mail to [human.resources@jud.ct.gov](mailto:human.resources@jud.ct.gov).

Under the State of Connecticut Workers' Compensation Act (Section 31-312 of the Connecticut General Statutes) you may be entitled to compensation for attending workers' compensation related appointments for medical treatment and tests. You are responsible for submitting an accurate record of any time taken for workers' compensation related appointments. This form must be completed in its entirety in order for your compensation eligibility to be determined. Failure to properly verify your workers' compensation medical appointment may result in time lost from work being charged to your time accruals without restoration.

- Note:** 1) Mileage reimbursement is dependent upon return of this completed form. Additional information regarding mileage reimbursement may be found in the Workers' Compensation Employee Informational Packet located on the Judicial Branch Intranet.
- 2) This form does not replace the worker's status report provided by your doctor.

<b>TO BE COMPLETED BY EMPLOYEE:</b>			
Employee Name		Employee ID Number	
Appointment Date	Scheduled Work Hours	Time Left from Work/Home	Time Returned from Appointment ( <i>if applicable</i> )
Departure Address			
Arrival Address			
Signed ( <i>Signature of Employee</i> ) ▶		Print or type name of person signing	

<b>TO BE COMPLETED BY MEDICAL PROVIDER:</b>				
Appointment Date	Date of Injury	Arrival Time	Departure Time	Follow-up Appointment Date
Appointment Address				
Signed ( <i>Signature of Medical Provider or Representative</i> ) ▶			Print or type name of person signing	

<b>HUMAN RESOURCE MANAGEMENT OFFICE USE ONLY:</b>		
Number of Hours	Hourly Rate	WC Adjuster