

60-day Initial

30-day Extension Slot Number _____

DAS Workers' Compensation Selective Duty Form

PER WC 146 / Revised 2009

INSTRUCTIONS:

1. Complete all sections below.
2. Send this form and a copy of the PER-WC 208 to the DAS Workers' Compensation Unit, 5th Floor East, 165 Capitol Ave., Hartford, CT 06106

Requesting Agency	Address (Street, City, ZIP)	Employee ID #
Employee Name	Social Security Number	Present Classification

INJURY INFORMATION

Date of Injury	Date of Disability	Type of Disability
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WAGE INFORMATION

Base Pay Annual: _____ Bi-Weekly Wage: _____ Hourly Wage: _____

Shift Differential: Yes ___ No ___ Weekend Differential: Yes ___ No ___ Premium Holiday: Yes ___ No ___

SELECTIVE DUTY ASSIGNMENT

Light Duty Assignment: From: _____ To: _____
mo/day/year mo/day/year

Report Station (address) _____ Supervisor Name _____
_____ Telephone _____

WC Contact Person _____ Telephone _____

JOB DUTIES: _____

I, certify that I have read and understand the above terms and acknowledge that I will participate in the Selective Duty Program under the conditions specified.

EMPLOYEE SIGNATURE: _____ DATE: _____

AGENCY PERSONNEL ADMINISTRATOR SIGNATURE: _____ DATE: _____

MEDICAL

Attach a copy of the medical report supporting the selective duty assignment or PER-WC208.

Workers' Compensation Unit _____ Date: _____