

Slot Number \_\_\_\_\_

# DAS Workers' Compensation Selective Duty Reconciliation Form

Revised 2009

**INSTRUCTIONS:**

1. Complete and attach this form to the Transfer Invoice after the employee completes the selective duty assignment.
2. Include a copy of the employee's time sheet.
3. Send all documents to the Department of Administrative Services Workers' Compensation Unit, 165 Capitol Ave., 5th Floor East, Hartford, CT 06106.

Employee Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_ Employee ID # \_\_\_\_\_

Employing State Agency \_\_\_\_\_

Selective Duty Assignment: From \_\_\_\_\_ To \_\_\_\_\_  
mo/day/year mo/day/year

<u>Pay Period</u>	<u>Base Pay Exclusive of Paid Leave</u>	<u>Regular Schedule Shift Differential Hours</u>	<u>Regular Schedule Weekend Differential Hours</u>	<u>Premium Holiday</u>	<u>Total</u>	<u>Remarks</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
<b>Totals</b>	_____	_____	_____	_____	_____	_____

Did employee return to regular duty? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Return \_\_\_\_\_  
mo/day/year

If no, did employee return to workers' compensation status? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Return \_\_\_\_\_  
mo/day/year

Other - Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone: \_\_\_\_\_