

Days Missed

Worker's Compensation

We need to verify the following information for the work injury you sustained. If you have questions be sure to call Human Resources (801) 851-8158

Please **DO NOT** include the first day of injury in the totals below.

_____ NUMBER OF **DAYS AWAY FROM WORK** BECAUSE OF INJURY

_____ NUMBER OF DAYS OF **LIGHT DUTIES ACTIVITY** BECAUSE OF INJURY

Signature

Date

NAME: _____

DEPT: _____