WORKERS' COMPENSATION FIRST CHECK PROCESS

_____ Process Level

_____ Accident Fund Claim Nbr.

_____ Last Name

_____ First Name

____ MI

_____ Social Security Nbr.

_____ Employee Nbr.

INJURY INFORMATION

_____ Date of Injury

_____ Last Day Worked

_____ Return to Work Date

_____ Partial Return to Work Date

TYPE OF CLAIM

Non Assault Employee _____

Rate of Pay $ _____

Public Act (Assault) Employee _____

Rate of Pay at Time of Injury $ _____

True Marital Status: Married ____ Single ____

True Number of Exemptions: ____

PAYMENT

$ _____ Initial Accident Fund Amt.

_____ Time Period 1st Check Covers

$ _____ Accident Fund Wkly Amt.

Bi-Weekly Standard Hours _____

Shift 2 _____
Shift 3 _____

Special Pay Premium Code _____

Will leave time be used? _____ Y/N

Type of Leave
(List in the order to be used)

1. _____
2. _____
3. _____

Additional Information _____

_____

_____

***Attach copy of DCDS time records with corrections for the time period specified above.
***Fax the completed form to 517-241-8509

CONTACT

Contact Person _____

Phone Number _____ Fax _____ Email _____