COLR - **Workers Compensation Work Status Form**

Acknowledgement Statement

This form is used to document the work status of an employee following a work-related injury. It must be completed and submitted within 24 hours of the employee's medical evaluation, per departmental guidelines.

Section 1: Employee Information

- **Full Name (print):**_____
- **Date of Injury:** _____
- **Medical Facility:** _____
- **Date Evaluated:** _____
- **Restrictions:** _____

Section 2: ***SUPERVISOR ONLY***

☐ **No Modified Duty Available - Last Date of Work:** _____

☐ **Full Duty Release - Return to Work Date:** _____

Authorizing Personnel Signature: _____ **Date:** _____

Section 3: ***EMPLOYEE ONLY***

☐ **ACCEPTED**
- MDAD:_____ (Modified Duty Acceptance Date)
- MDRD:_____ (Modified Duty Return Date)

☐**DECLINED - Last Date of Work:** _____

Pursuant to AR Code § 11-9-526

I understand that if I decline the available modified duty, my claim is not eligible for workers compensation compensatory benefits. **(Employee Initials: _____)**

Employee Signature: _____ **Date:** _____

Email completed form to the below corresponding parties.

LRPD:

Workerscompnotifications@littlerock.gov

LRFD & NON UNIFORM DEPTS:

riskmanagement@littlerock.gov & Cheri_Beard@ajg.com