South Carolina

State Accident Fund

Henry D. McMaster
Governor

Erin Farthing
Director

Workers' Compensation lost time and return to work form

Employee Name:
SAF Claim #

_______________________ went out of work on _____________.
(Injured workers' name) (Date)

While out of work, injured workers' time was coded:

1. Using sick leave and/or PTO beginning on __________and ending on _________.
(Do not include ending date if injured worker is still receiving sick leave or PTO while out of work)

2. On LWOP (leave without pay) beginning on _________and ending on _________.
(Do not include ending date if injured worker is still on LWOP while out of work)

If the injured worker has returned to work please complete the following:

_____________________ returned to work on ____________ [ ] Light/ modified duty [ ] Full duty
(Injured workers' name) (Date)

[ ] In the same department
[ ] In a different department but receiving the same salary
[ ] In a different department and receiving a different salary (please include amount of hours per week and/or hourly wage if different ____________________________.

Accommodating department and/or new position___________________________.

Completed by:

Name: ______________________ Date: ______________________

Position/title: _________________ Phone number: ________________