



Note: Some features may not work when completing the form in the browser. Please download forms to a PDF before entering information. All forms are downloadable PDFs.

Mail completed form to:
Division of Finance-Payroll
PO Box 141031
Salt Lake City, UT 84114-1031
Email: payroll@utah.gov

If questions, call (801) 957-7770

WORKERS COMPENSATION ADJUSTMENT FORM

Name _____ Employee Number _____

Dept. Name _____ Division _____

Unit _____ Distribution Code _____ Hourly Rate _____

Beginning Date of Sick Leave _____ Ending Date of Sick Leave _____
MM/DD/YYYY MM/DD/YYYY

Number of Hours to be Reinstated:

Annual Leave	Sick Leave	Converted Sick
Comp Time	Excess	Total

Amount to be Repaid _____

Contact Person _____ Contact Person's Phone _____

Dept. Approval Name _____ Title _____

Department Approval _____ Date _____

Reminders

Did you attach the check?

Did you adjust the leave balance?