FI 24
07/2018
Division of Finance

Clear Form

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 0.00

Amount to be Repaid _____

Contact Person _____ Contact Person's Phone _____

Reminders

☐ **Did you attach the check?**

☐ **Did you adjust the leave balance?**