Employer Supplemental Report

Employer: Fill out this form and send the original to your workers' compensation insurer at the following times:

1. Upon termination of disability (regardless of length of time disabled from work).
2. At the end of 60 days from the date disability began if employee is disabled that long.

<table>
<tr><td>Name of injured employee:</td><td>Address where mail should be sent:</td></tr>
<tr><td>Date of injury:</td><td>Date disability began:</td></tr>
<tr><td>Were wages paid for the day the disability began?
☐ Yes ☐ No</td><td>What wages, if any, have been paid during the period of disability?</td></tr>
<tr><td rowspan="2">Has the injured employee returned to work?
☐ Yes ☐ No</td><td>If so, on what date was he re-employed?</td></tr>
<tr><td>At what daily wage?</td></tr>
<tr><td>At light or regular work?
☐ Light duty ☐ Regular work</td><td>If re-employed at less wages than received before the injury, give reason:</td></tr>
<tr><td colspan="2">Give date the injured employee recovered sufficiently to return to regular work:</td></tr>
</table>

THE ABOVE STATEMENTS ARE CORRECT

(The employee MUST NOT sign this form BEFORE the work disability ceases)

Employer

Signature of injured employee

Signature of Authorized Agent

Date of this report

Address