

**WORKERS' COMPENSATION LOST TIME REPORT**

HUMAN RESOURCES  
WORKERS' COMPENSATION DIVISION  
P. O. BOX 1120  
RIVERSIDE, CA 92502-1120  
Or MAIL STOP 2180

FROM: \_\_\_\_\_  
SIGNED: \_\_\_\_\_  
DATE: \_\_\_\_\_

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**LOST TIME REPORT**

EMPLOYEE NAME: \_\_\_\_\_ EMPLOYEE #: \_\_\_\_\_  
DEPARTMENT NUMBER: \_\_\_\_\_ FUND #: \_\_\_\_\_ ORG #: \_\_\_\_\_  
DATE OF INJURY: \_\_\_\_\_ REGULAR SCHEDULED DAYS OFF IF NOT  
SATURDAY AND SUNDAY: \_\_\_\_\_  
LAST DATE WORKED: \_\_\_\_\_

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**RETURN TO WORK NOTICE**

DATE RETURNED TO WORK: \_\_\_\_\_ TOTAL DAYS LOST DUE TO INJURY: \_\_\_\_\_  
REMARKS; \_\_\_\_\_  
\_\_\_\_\_  
SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

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SEND WHITE COPY WHEN EMPLOYEE IS OFF WORK DUE TO INJURY.  
SEND THE YELLOW WHEN THE EMPLOYEE RETURNS.  
PINK IS FOR DEPARTMENT FILE COPY.

**THE PHYSICIAN'S ORIGINAL  
MEDICAL SLIP AUTHORIZING  
TIME OFF MUST BE ATTACHED**

WC-6 (Rev 11/03)