RETURN TO WORK REIMBURSEMENT PROGRAM

*INVOICE STATEMENT*

School District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim: #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility/Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pay Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_THRU \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|  |  |  |  |  |  |  |  |  |  |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|  |  |  |  |  |  |  |  |  |  |
| 31 |
|  |

* In the above calendar, please record – by date, the hours worked by the above employee. Please place an “A” in those dates he/she was scheduled to work but was unable to due to absence unrelated to the injury/claim.
* The completed invoice statement must be submitted for reimbursement to the ESD 113 Workers’ Compensation Trust within 60 days from the end of the month that light duty was performed in.
* **Under penalty of perjury and possible suspension and/or dismissal, I declare the above hours worked to be correct and complete.**
* **Reimbursement requests cannot exceed the number of hours the disabled employee normally worked at the time of their injury, and does not include pay for holiday, annual leave or sick leave.**

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SUPERINTENDENT****,* ***BUSINESS MANAGER OR PAYROLL APPROVAL***

Total Hours Worked: \_\_\_\_\_\_\_ x Rate of Pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ = $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ *Superintendent, Business Mgr. or Payroll Rep Date ESD 113 Claims Representative Date*