

Claimant's Name _____				SSN _____	Employer's Name _____			
Address _____	City _____	State _____	Zip _____	Address _____	City _____	State _____	Zip _____	
Home Phone # _____		Work Phone # _____		Insurance Carrier _____				
Preparer's Name _____				Phone # _____				

Date of injury: _____
month day year

1. Temporary Compensation Paid:

Number of Weeks	From	TO	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. The claimant returned to work on _____
month day year With restrictions but at a salary not less than before the injury.
 Without restrictions.

3. The claimant agrees he or she was able to return to work on _____
month day year

I agree that I was disabled for the period(s) indicated and I was paid compensation as shown above. **I UNDERSTAND THAT MY WEEKLY TEMPORARY COMPENSATION CHECKS WILL STOP; HOWEVER, I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT, OR MEDICAL CARE.** The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work or agree I was able to return to work.

Claimant's Signature

Employer's Representative Signature

(Check one) Witness Claimant's Attorney

Date Agreement Signed

File this form with the Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 day period, obtain a Form 17 to document that claimant agrees he or she is able to return to work.