



Workers Compensation Adjustment Form

Name Employee Number

Dept. Name Division

Unit Distribution Code Hourly Rate

Beginning Date of Sick Leave MM/DD/YYYY Ending Date of Sick Leave MM/DD/YYYY

Number of Hours to be Reinstated:

Annual Leave	Sick Leave	Converted Sick
Comp Time	Excess	Total

Amount to be Repaid

Contact Person Contact Person's Phone

Reminders

Did you attach the check?

Did you adjust the leave balance?