

- 60-day Initial
- 30-day Extension

# DAS Workers' Compensation Selective Duty Form

PER WC 146 / Revised 2008

**INSTRUCTIONS:**

1. Complete all sections below.
2. Send this form and a copy of the PER-WC 208 to the DAS Workers' Compensation Unit, 5th Floor East, 165 Capitol Ave., Hartford, CT 06106

Requesting Agency	Address (Street, City, ZIP)	MSA Payroll Unit
Employee Name	Social Security Number	Present Classification

**INJURY INFORMATION**

Date of Injury	Date of Disability	Date of Disability
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**WAGE INFORMATION**

Base Pay Annual: \_\_\_\_\_ Bi-Weekly Wage: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Shift Differential: Yes \_\_\_ No \_\_\_ Weekend Differential: Yes \_\_\_ No \_\_\_ Premium Holiday: Yes \_\_\_ No \_\_\_

**SELECTIVE DUTY ASSIGNMENT**

Light Duty Assignment: From: \_\_\_\_\_ To: \_\_\_\_\_  
mo/day/year mo/day/year

Report Station (address) \_\_\_\_\_ Supervisor Name \_\_\_\_\_ Telephone \_\_\_\_\_

WC Contact Person \_\_\_\_\_ Telephone \_\_\_\_\_

JOB DUTIES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*I, certify that I have read and understand the above terms and acknowledge that I will participate in the Selective Duty Program under the conditions specified.*

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**AGENCY PERSONNEL ADMINISTRATOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MEDICAL**

*Attach a copy of the medical report supporting the selective duty assignment or PER-WC208.*

Workers' Compensation Unit \_\_\_\_\_ **Date:** \_\_\_\_\_