MICHIGAN STATE UNIVERISTY
WORKERS' COMPENSATION DIVISION
INJURY ABSENCE REPORT
(To be submitted prior to the close of each pay period)

Date: _____

Name: _____

Department: _____ Date of Injury: _____

Last Day Worked: _____ Current Sick Leave Hours Available: _____
(as of last day worked)

Date Employee Returned to Work: _____ **CURRENT** Rate of Pay: $_____ per _____

Normal work schedule:

_____

Indicate below the work hours lost by day due to injury:
(Report only FULL shifts/days)

Month: _____

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Hours Lost																	
Day of Month	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total Hours Lost
Hours Lost																	

DISTRIBUTION:
Original – Workers' Compensation
Copy to Department

_____
Departmental Authorized Signature

MSU is an affirmative-action, equal opportunity employer.

Last updated: 11/1/2012