Print Form

CLAYTON COUNTY BOARD OF COMMISSIONERS

WORKERS' COMPENSATION PAY PERIOD SUMMARY

Employee Name: _____ Department: _____

Date of Injury: _____ Pay Period Beginning _____ Ending _____

Did the employee lose any time from work this pay period due to the work related injury on the above date? ☐ YES ☐ NO

If the employee lost time, did they miss the entire pay period due to the worker related injury? ☐ YES ☐ NO

Indicate the days absent in the chart below: (note the reporting codes listed below)

Insert the date of the month above the day of the week. Insert the reporting code and actual number of hours missed below the day of the week. Insert the employee's scheduled days off.

Date:	Date:	Date:	Date:	Date:	Date:	Date:
SAT	SUN	MON	TUE	WED	THUR	FRI
Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:

Date:	Date:	Date:	Date:	Date:	Date:	Date:
SAT	SUN	MON	TUE	WED	THUR	FRI
Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:	Code: Hours:

WC = Hours missed due to **Workers' Comp** injury
125 = W/C
116 = W/C Sick Leave
150 = W/C Leave without pay

RMD = Date employee returned to **Modified** duty

RR = Date employee returned to **Regular** duty.

Sign Here After Printing

_____ _____

Department Head Signature Date

FORM "B"

Return completed original form to HR/Workers' Compensation Division

Revised 8/2009