Requesting Agency   Employee Name   Employee Title   Employee ID   Hourly Wage    Date of Injury   Date of Disability   Type of Injury   Social Security Number   Isst 4 digits only: XXX-XX-  SELECTIVE DUTY ASSIGNMENT   Light Duty Assignment:   From:   To:	_	ons I a copy of the PER-WC-20 t, 450 Columbus Blvd, STE				DAS Workers' Compensate Selective D Per WC 146/ Revise	uty Form	
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SELECTIVE DUTY ASSIGNMENT Light Duty Assignment: From: To:    mo/day/year	Requesting Agency	Employee Name	Empi	loyee little		Employee ID	Hourly wage	
SELECTIVE DUTY ASSIGNMENT Light Duty Assignment: From: To:    mo/day/year	Date of Injury	Date of Disability	Туре	of Injury		Social Security Nu	mber	
SELECTIVE DUTY ASSIGNMENT Light Duty Assignment: From: To:  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:  MEDICAL ATTOCA a copy of the medical report supporting the selective duty assignment or PER-WC-208	, ,							
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MEDICAL Attach a copy of the medical report supporting the selective duty assignment or PER-WC-208					Date:	_		
Attach a copy of the medical report supporting the selective duty assignment or PER-WC-208	AGENCY PERSONNEL	ADMINISTRATOR SIGNAT	URE:		Date:	_		
DAS WORKERS' COMPENSATION UNIT Date:								
	DAS WORKERS' COM	PENSATION UNIT			Date:			