Slot Number _____

DAS Workers' Compensation Selective Duty Form

Per WC 146/ Revised 2018

INSTRUCTIONS:

1. ***Complete All Sections***
2. ***Send this form and a copy of the PER-WC-208 to the DAS Workers' Compensation Unit, 450 Columbus Blvd, STE 1401, Hartford, CT 06103***

AGENCY/EMPLOYEE INFO

Requesting Agency	Employee Name	Employee Title	Employee ID	Hourly Wage

Date of Injury	Date of Disability	Type of Injury	Social Security Number last 4 digits only: XXX-XX-

SELECTIVE DUTY ASSIGNMENT

Light Duty Assignment: From: _____ (mo/day/year) 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:** _____

AGENCY PERSONNEL ADMINISTRATOR SIGNATURE: _____ **Date:** _____

MEDICAL

Attach a copy of the medical report supporting the selective duty assignment or PER-WC-208

DAS WORKERS' COMPENSATION UNIT **Date:**

_____ _____