DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

VERIFICATION OF MEDICAL APPOINTMENT FORM

This form must be completed by the Medical Service Provider

Employees must take this form to each workers' compensation medical appointment made during or after their regular working hours. The employee's time sheet should be coded "WSPC" for the time it takes the employee to travel to the appointment, while they are at the appointment, and the time it takes the employee to return to work.

Employees' will be paid only for the time at the appointment when the appointment is after work hours, or on scheduled days off. Payment for these appointments will be paid through the Third Party Administrator, and not through payroll.

This form **must** be attached to the corresponding time sheet, or faxed to the Departments Workers' Compensation Unit. (Fax # 860-622-2927)

Employee Name: _____Employee # _____

Medical Service Provider: _____

Appointment Date: _____ Appointment Start Time: _____

Appointment End Time : _____

Scheduled Work Hours on Appointment Date: _____

Is this appointment due to a work related injury/illness? _____ yes DOI_____
_____ no

_____ _____

Medical Service Provider Signature **Date**

Address **Town,** **State**