



## Return-to-Work Notice

Return completed form to:

BrickStreet Insurance

P.O. Box 3151

Charleston, WV 25332-3151

Claimant's Name:

Claimant's Address:

City, State, Zip:

Claim Number:

Social Security Number:

Date of Injury:

The above named employee began MISSING work on:

The above named employee RETURNED to work on:

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Employer: \_\_\_\_\_

Date: \_\_\_\_\_

GIVE CLAIMANT'S COMPLETE NAME AND ADDRESS. PLEASE TYPE OR PRINT USING INK PEN TO INSURE CLARITY.