MICHIGAN STATE UNIVERISTY
WORKERS' COMPENSATION DIVISION
INJURY ABSENCE REPORT
(To be submitted prior to the close of each pay period)

Date: ____________

Name: ________________________________

Department: ____________________ Date of Injury: ____________________

Last Day Worked: ____________________ Current Sick Leave Hours Available: ________
(as of last day worked)

Date Employee Returned to Work: __________ **CURRENT** Rate of Pay: $ ________ per ______

Indicate below the work hours lost by day due to injury:
(Report only FULL shifts/days)

Month: ____________________

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Hours Lost																	
Day of Month	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total Hours Lost
Hours Lost																	

DISTRIBUTION:
Original – Workers' Compensation
Copy to Department

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Departmental Authorized Signature

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