

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

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

Name: \_\_\_\_\_ Person ID: \_\_\_\_\_

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: \_\_\_\_\_ Month: \_\_\_\_\_  
 (Report only FULL shifts/days)

|              |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |                  |  |
|--------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|------------------|--|
| 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

\_\_\_\_\_  
 Departmental Authorized Signature