BI-309

01/06

Return to Work Notice

Return completed form to:
BrickStreet Mutual Insurance
P.O. Box 3151
Charleston, WV 25332-3151

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

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: ______________________