FILE SUMMARY FORM

Employee Name: ______________________ Position/EFT: ______________________

Site: ______________________ Supervisor: ______________________

Claim #: ______________________

☐ WCB ☐ MPI ☐ HEB ☐ CL Income Protection ☐ Yes ☐ No

Date of Initial Leave of Absence: ______________________

Date of Work-Related Injury: ______________________

Date of RTW Modified Duties: ______________________

Date of RTW Full Duties: ______________________

Permanent Restrictions:

Comments:

File Closure Date: ______________________

Manager Signature: ______________________ Date: ______________________

For Workplace Safety & Health program only
☐ E-mails electronically transferred ☐ All files electronically transferred