WORKERS' COMPENSATION REIMBURSEMENT REQUEST

DATE:

TO:

RE:

We have paid full wages to this employee from _____ to _____ while he/she was disabled as a result of a work-related illness/injury.

Payment was made at the rate of $_____ per week and we have paid a total of $_____.

We hereby request reimbursement for wages paid as advance compensation during the employee's disability, and in full if an award for facial disfigurement, schedule loss, or loss of use is made.

_____
Firm Name

BY _____
Title