



Return-to-Work Notice

Return completed form to:
BrickStreet 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: _____