

WAGE AND STATUS –LEAVE DUE TO WORKERS COMPENSATION OR FMLA/VTSELA

BENEFITS ELIGIBLE: ___ YES ___ NO

GENERAL INFORMATION

First Name	Middle Initial	Last Name	Suffix (Jr, Sr, III, etc.)
Social Security Number			

JOB INFORMATION

Job Title/Job Code	Supervisor Name	Location	Department
Effective Change Date	Work Location	Annual Salary/Hourly Rate	Full Time Hourly ___ F/T Salary ___ Part Time ___ Per Diem ___
			Bi-Weekly Hours _____ Night shift? Yes ___ No ___

Workers Compensation (If employee goes out due to workers compensation then the FMLA/VT Medical/Family/Parental leave paperwork for leave must be completed)		Workers Compensation	
First Report of Injury Date: _____ Date of Leave: _____		Date of Return	
FMLA or VT State Medical/Family/Parental Leave (Approved leave through HR only)	Date of Leave	Date of Return	

TO BE COMPLETED BY PAYROLL

Employee Number	Position Number	Bi-weekly/Hourly Rate	Entered By	Date

Supervisor Signature _____ Date _____

Comments:
