

RELEASE TO RETURN TO WORK

PLEASE PRINT OR TYPE

Instructions: This form must be completed by the adjuster after receiving a physician notification of release to return to full or light duty work. The form must be submitted to the Labor Commission and to the injured worker within five (5) days of the release date.

General Information

Worker Name _____
Address _____
Phone Number _____ SS# _____

Injury Date _____
Employer _____
Actual # of Lost Work Days _____

Released to Regular Duty

Date _____

Permanent Impairments, if any:

Released to Light Duty

Date _____

Permanent Impairments, if any:

Anticipated Date of Release to Regular Duty:

Name of Person Submitting Form _____

Carrier Name _____

Phone Number _____

Date Submitted _____



Official Form 110 Revised **05/16**

State of Utah * Labor Commission * Division of Industrial Accidents

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