

SC / OIL Hourly Payment Request Form

Employee and Employer Statement

Please read the instructions on page 2 before completing the application

PERSONNEL OFFICE USE ONLY

Date Received in Office

Employee Section

Employee's name:

BWC Claim #:

Date of Injury:

Employee ID #:

Name of physician (please print):

Physician phone #:

I am a full-time permanent employee on a transitional work assignment equivalent to my regularly scheduled hours and am continuing to seek treatment related to my workers' compensation claim.

I am requesting _____ Salary Continuation Benefits **or** _____ Occupational Injury Leave benefits

for date: _____ hour: _____

date: _____ hour: _____

date: _____ hour: _____

date: _____ hour: _____

In order to be eligible to receive payment in hourly increments, I have;

_____ attempted to schedule my appointment during non-working hours and;

_____ worked with my employer to flex my schedule to accommodate the appointment

I understand that if I have not explored the above two options, I am not eligible to receive payment for my physician appointment.

Employee Certification / Authorization

Employee Signature

Date

Employer Section

Employer name:

BWC Policy #:

Total hours of _____ SC or _____ OIL requested: _____

Is the employee participating in a transitional work assignment working regularly scheduled hours?
_____ Yes _____ No

Employer recommends: _____ approval

_____ denial

Has the employee attempted to schedule his/her appointment during non working hours?
_____ Yes _____ No

Employer comments:

Has the employee worked with the employer in attempt to flex his/her schedule to accommodate the appointment?
_____ Yes _____ No

Employer Designee Signature

Date

Employee & Employer Instructions for completing the (form name)

This form must be completed as part of the Workers' Compensation application process. Failure to fully complete this report may result in the denial or delay of benefits. Write legibly with a pen or electronically (do not use pencil).

Employee Section

The injured employee is responsible for completing the employee section

Employee Certification / Authorization

Please read and complete the employee's section in its entirety. Date and sign this report and return to your employing agency designee/personnel officer.

Employer Section

The employer is responsible for completing the employer section