

NOTICE OF RETURN TO WORK (Form 5)

In regards to claim of:

Full Name of Claimant (Injured Employee)

Claimant's Social Security Number

Name of Employer or Respondent

National Security

Name of Employer's Insurance Carrier

Name of injured employee:

Address:

Date of injury:

Has injured employee been released to return to work? _____ If so, what date?

Has employee returned to work for you? _____ If so, what date?

Is employee earning the same wage?

Has employee accepted other employment? _____ If so, what date?

If so, where is the employee employed? _____

Has employee died?

I declare under penalty of perjury that I have examined this notice and statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Signed this _____ day of _____, 20____

Signature of Employer or Authorized Representative

Title of Person Signing: _____

Mail To: Department of Corrections
P.O. Box 11400
Oklahoma City, OK 73136

Form 5

(R 4/16)