



FORM 226
WORKERS' COMPENSATION HEARINGS

WORKERS' COMP COMMISSION PERSONNEL COMPLETES:

CLAIMANT'S NAME: _____

HEARING DATE: _____ DATE OF INJURY: _____

ARRIVAL TIME: _____ DEPARTURE TIME: _____

WORKERS' COMPENSATION DISTRICT # _____

SIGNATURE: _____

W/C COMMISSION PERSONNEL

THIS FORM MUST BE SUBMITTED TO KATHY ROULEAU (MC 4035 OR FAX 860-679-4660) IN ORDER TO RECEIVE PAYMENT DIRECTLY FROM THE W/C CARRIER. CONTACT 860-679-4589 WITH QUESTIONS.

EMPLOYEE COMPLETES (CHOOSE ONE BOX ONLY AND COMPLETE):

THIS APPOINTMENT OCCURRED:

- BEFORE/AFTER WORKING HOURS** (*THIS SHOULD NOT APPEAR IN KRONOS; REIMBURSEMENT FOR THE TIME WILL COME DIRECTLY FROM THE W/C CARRIER.*)

Appointment plus travel time: _____
(ROUND UP OR DOWN TO NEAREST 15 MIN. INTERVAL)

- DURING WORK HOURS:**

Appointment plus travel time: _____
(ROUND UP OR DOWN TO NEAREST 15 MINUTE INTERVAL)

- PARTIALLY DURING WORKING HOURS AND PARTIALLY BEFORE/AFTER WORK** (*USE 226 CODING IN KRONOS FOR TIME MISSED DURING WORKING HOURS ONLY. REIMBURSEMENT FOR THE REMAINDER WILL COME DIRECTLY FROM THE W/C CARRIER.*)

▪ Total number of hours during work (including travel): _____
(ROUND UP OR DOWN TO NEAREST 15 MIN INTERVAL)

▪ Total number of hours before/after work (including travel): _____
(ROUND UP OR DOWN TO NEAREST 15 MIN INTERVAL)

HR COMPLETES:

NUMBER OF HOURS: _____ HOURLY RATE: _____ EMPLOYEE ID: _____

ADJUSTER: _____