MC Innovations Workers' Compensation
Supplementary Work Status Report

Agencies may use this form to communicate changes in an employee's work status to MC Innovations. Complete and send to MCI using any of the below methods:

Mailing address: P.O. Box 1140, Richmond, VA 23218-1140

Fax: 804.371.2556

Email: Covimaging@sedgwick.com

MCI Claim Number:

Injured Worker Name:

Injured Worker Date of Accident:

1	Name of Employer			
2	Office Address: Number and Street		City or Town	State
3	Injured's Last Name	Injured's First Name		Injured's Middle Name
4	Present Address: Number and Street		City or Town	State
5	Date disability began	AM or PM		
6	Has Injured returned to work?	If so, date and hour		AM or PM
7	Is injured person earning same wages as before injury?		Yes or No	If not, explain:
8	If disability has not terminated, state probable date of termination of disability.			
9	Has Injured died?	If so, date of death		AM or PM

Name:_____ Date:_____

Title:_____ Signature:_____