

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
CONCORD, NH 03301

REPORT OF EXTENDED DISABILITY

This form shall be completed by the Insurer or Self-Insurer and filed with the Department on every case where total disability benefits are anticipated to or have continued for six months as required by Administrative Rule Lab 509.03 in accordance with RSA 281-A:25.

Claimant _____ S.S. No. _____
(First Name) (Middle Initial) (Last name)

Address _____
(No.) (Street/P.O. Box or RFD No.) (City/Town) (State) (Zip Code)

Telephone Number _____
(Area) (Number)

Check (-): Male Female Age

Education, Select Highest: 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4
(Primary) (Secondary) (College)

Injury Date _____ Disability Date _____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

Nature and Location of Injury

Employer's Name

Office Address _____
(No.) (Street/P.O. Box or RFD No.) (City/Town) (State) (Zip Code)

Telephone Number _____ Employer's I.D. # _____

Carrier Name _____ Carrier # _____

Address _____

Date employer was contacted as to claimant's return to employment _____

Employer's response: Yes No _____
(Name of Person Contacted)

If yes, in what capacity

(Date)

(Carrier Representative's Signature)