



**REPORT OF TEMPORARY TOTAL DISABILITY (TTD) /  
TEMPORARY PARTIAL DISABILITY (TPD)  
TERMINATION / REDUCTION**

State Form 38911 (R7 / 8-10)

**INDIANA WORKER'S COMPENSATION BOARD**  
402 West Washington Street, Room W196  
Indianapolis, IN 46204  
Telephone: (317) 232-3808

\* Your Social Security number is being requested by this state agency in accordance with IC 22-3-4-13; disclosure is voluntary, and you will not be penalized for refusal.

- INSTRUCTIONS:** 1. You must report all compensation payments on this prescribed form. (IC 22-3-3-7)  
2. Mail to the Worker's Compensation Board at the above address.

Date of injury (month, day, year)		Accident number		
<b>CLAIM INFORMATION</b>				
Name of employer		Federal identification number		Telephone number ( )
Address of employer (number and street, city, state, and ZIP code)				
Name of insurer			Insurer claim number	
Address of insurer (number and street, city, state, and ZIP code)				
Name of adjuster / case manager		Telephone number ( )	E-mail address	
Name of employee			Employee Social Security number *	
Address of employee (number and street, city, state, and ZIP code)				
Telephone number ( )		E-mail address		
<b>BENEFIT TERMINATION / REDUCTION (check all that apply)</b>				
<input type="checkbox"/> In accordance with IC 22-3-3-7 (c), TTD/TPD benefits have been terminated due to the following (check all that apply): <input type="checkbox"/> The employee has returned to <b>ANY</b> employment for (name of employer) _____; <input type="checkbox"/> The employee has died; <input type="checkbox"/> The employee has refused to undergo a medical examination or treatment ordered by the treating physician, which suspends the employee's right to compensation and the right to prosecute any proceedings until such refusal ceases (22-3-3-6); <input type="checkbox"/> The employee has refused to accept suitable employment, which suspends the employee's right to any compensation until such refusal ceases (22-3-3-11); <input type="checkbox"/> The employee has received five hundred (500) weeks of TTD benefits or has been paid the maximum compensation allowed under IC 22-3-3-22; <input type="checkbox"/> The employee is unable or unavailable to work for reasons unrelated to the compensable injury. <b>(IF BOXES BELOW ARE CHECKED, MEDICAL DOCUMENTATION MUST BE ATTACHED.)</b> <input type="checkbox"/> TTD benefits shall be reduced to the appropriate Temporary Partial Disability (TPD) because employee has been released to part time work suitable to employee's disability. <input type="checkbox"/> Employer intends to terminate TTD/TPD benefits on _____ (must be at least 4 days after mailing or 2 days after personal service) because: <input type="checkbox"/> Treating physician has released employee to full time light duty work and employer has appropriate light duty work available. <input type="checkbox"/> Treating physician finds employee has reached MMI and/or employee is released to full time work (check one): <input type="checkbox"/> With restrictions <input type="checkbox"/> Without restrictions <input type="checkbox"/> Other				
Explanation				
<b>COMPENSATION PAYMENTS</b>				
Average weekly wage \$	Number of weeks paid	Weekly rate \$	Start date of payments (month, day, year)	End date (month, day, year)
Total amount paid \$	Check one. <input type="checkbox"/> Employee <input type="checkbox"/> Dependent		Reason(s) for ending payments	
<b>EMPLOYEE'S OBJECTION TO TERMINATION OF TTD BENEFITS</b>				
Employees who disagree with proposed benefit termination must complete, sign and return a copy of this form to the <b>Worker's Compensation Board</b> and <b>the employer</b> within <b>seven (7) days</b> after receiving it.				
Please check all that apply. <input type="checkbox"/> Employee disagrees with the termination / reduction of benefits. <input type="checkbox"/> Employee requires further medical care. <input type="checkbox"/> Employee believes an independent medical examination (IME) may be helpful to resolve this dispute.				
Explanation				
<b>EMPLOYER CERTIFICATION / RECEIPT OF EMPLOYEE / DEPENDENT</b>				
Employer and employee must sign below to certify service or acknowledge receipt of this notice. I certify that the foregoing is true and that a copy of the relevant medical documentation is attached.				
Signature of employer			Date signed (month, day, year)	
Printed name			By (check one): <input type="checkbox"/> US Mail <input type="checkbox"/> Personal service	
Signature of employee			Date signed (month, day, year)	
Printed name			By (check one): <input type="checkbox"/> US Mail <input type="checkbox"/> Personal service	