STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

REQUEST FOR WORK STATION EVALUATION

TO: DCF/HR
DCF- WORKERS' COMPENSATION UNIT
505 HUDSON STREET
HARTFORD, CT 06106

Fax# 860-560-7083 or 860-723-7246

*Employee Name:*_____ *Title*: _____

Location: _____ *Phone:* _____

Supervisor: _____ *Title:* _____

Phone#: _____ *Floor:* _____

Date of Request: _____/_____/_____ *Employee#* _____
MM/DAY/YEAR

Reason for Request:

_____
_____
_____
_____
_____
_____
_____
_____

IS THIS DUE TO A WORKERS' COMPENSATION INJURY: *YES* ____ *NO* ____

IF YES, DATE OF INJURY: _____

EMPLOYEE SIGNATURE: _____ *DATE*_____

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