EMPLOYEE'S REPORT OF INJURY

PERSONAL INFORMATION

NAME _____ CLAIM # _____

ADDRESS _____ HOME PHONE _____ CELL PHONE _____

Gender: ☐ MALE ☐ FEMALE

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

OCCUPATION _____ EMPLOYER _____ DEPARTMENT _____

EMPLOYER ADDRESS _____

NUMBER OF DAYS PER WEEK _____ NUMBER OF HOURS PER DAY _____ NORMAL DAYS OFF _____

LENGTH OF EMPLOYMENT _____ WAGES (HOURLY RATE OF PAY) _____

INJURY INFORMATION

DATE OF INJURY _____ TIME _____ DATE INJURY REPORTED _____

Accident reported to: _____ By (name): _____

Who witnessed accident (name & address for each person listed)? _____

_____

Describe fully how injury happened (continue on back if necessary): _____

_____

_____

_____

What part(s) of your body was injured? _____

Did you stop work as a result of your accident? ☐ YES ☐ NO When: _____

Was your pay continued during any part of your disability? ☐ YES ☐ NO

If so, for what period? _____ Last day for which you were paid? _____

If not working, date you expect to return to work? _____ If you did return to work, list date? _____

From whom did you receive first medical treatment (list date)? _____

Are you still under medical treatment? _____ How often do you receive treatment? _____

NAME OF DOCTOR _____ ADDRESS _____ PHONE _____

SIGNATURE

SIGNATURE _____ DATE _____ CLAIM # _____