

# 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 # \_\_\_\_\_