EMPLOYEE'S REPORT OF INJURY

EMPLOYEE DATA

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ GENDER _____

FULL NAME _____ PHONE _____

ADDRESS _____ WORK LOCATION _____

INJURY/MEDICAL DATA

LOSS DATE _____ DATE EMPLOYER NOTIFIED BY EMPLOYEE _____

WORKSITE LOCATION OF INJURY _____

TIME EMPLOYEE BEGAN WORK _____ TIME OF EVENT _____

Is the employee seasonal? ❍ YES ❍ NO

Did the employee die? ❍ YES ❍ NO

Will the employee miss more than 7 days of work? ❍ YES ❍ NO

How did the injury occur? _____

_____

BODY PART(S) INJURED _____

OCCUPATIONAL AND WAGE DATA

OCCUPATION _____ HIRE DATE _____

Pay rate: _____ ❍ HOURLY ❍ SALARY

Was medical treatment sought? ❍ YES ❍ NO

Where was medical treatment sought? _____

PREPARER INFORMATION

FULL NAME _____ PHONE _____

EMAIL _____ COMPANY NAME _____

SIGNATURE

SIGNATURE _____ DATE _____ CLAIM # _____