EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ Social Security:_____ Gender: M / F
Last First MI Maiden

Address:_____ Date of Injury: _____

City: _____ State: _____ Employer:_____

Primary Phone Number: _____ Job Title: _____

Secondary Phone Number: _____ Work Schedule:_____

Email address: _____

1) What was the exact location of the accident (street address if possible):

2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date_____ Time_____

Name: _____ Title_____ Phone Number: _____

6) List all known witnesses. (Continue on back if necessary) Name _____ Phone:_____

Name _____ Phone: _____ Name:_____ Phone:_____

7) Please identify your Primary Care Physician or family doctor: Name:_____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name:_____ Phone: _____

Name:_____ Phone:_____

Name:_____ Phone: _____

9) Has a doctor taken you off work? ___Yes ___ No If so, when was the first day you missed work ?_____

10) If the doctor took you off work, have you returned to work? ___Yes ___No If not, when do you think you will return to work?_____

11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ___Yes ___No If Yes, please enter dates of injuries and the body parts injured.

By affixing my signature, I attest that all information on this form is accurate and true.

Signature:_____ Date:_____