

# EMPLOYEE'S REPORT OF INJURY

## PERSONAL INFORMATION

NAME	CLAIM #	
ADDRESS/CITY	HOME PHONE	CELL PHONE
Gender: <input type="radio"/> MALE <input type="radio"/> FEMALE		
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
OCCUPATION	EMPLOYER	LOCATION
EMPLOYER ADDRESS/CITY		
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
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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? \_\_\_\_\_

Do you plan to seek medical treatment?  YES  NO If yes, where? \_\_\_\_\_

Are you still under medical treatment? \_\_\_\_\_ How often do you receive treatment? \_\_\_\_\_

NAME OF DOCTOR	ADDRESS/CITY	PHONE
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## SIGNATURE

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ CLAIM # \_\_\_\_\_