# EMPLOYEE'S REPORT OF INJURY

## PERSONAL INFORMATION

NAME | CLAIM #

ADDRESS | HOME PHONE | WORK PHONE

MARITAL STATUS | ❍ MALE ❍ FEMALE GENDER

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)

## DEPENDENT INFORMATION *(Complete the following if you have dependent children under 21 years of age living with you)*

Name of dependent child: Age: Name of dependent child: Age:

Name any dependent children not at least 50% supported by you:

## 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 #

March 2012