Employer Information Form

Company Name: _____ Name of Injured Employee: _____

Form Completed By: _____ Date of Birth: _____

Today's Date: _____ SSN: _____

Policy Number: _____ Date of Injury: _____

I. LOST TIME

Did the injured employee lose any time from work? Yes____ No ____

Did the employee leave work to seek medical treatment? Yes ____ No ____

If yes, did he/she return to work after appointment? Yes ____ No ____

When is the employee's next scheduled shift? _____

If the employee is disabled from working, when is his/her anticipated return to work date? _____

Please indicate the date(s) the employee missed work and the number of hours on each day.

_____

II. MEDICAL TREATMENT

Did the employee seek medical treatment? Yes ____ No ____

- ▫ If yes, where? _____Phone Number:_____
- ▫ If no, does the employee intend to seek medical treatment? Yes____ No_____

Is a follow-up doctor appointment scheduled? Yes ____ No _____

- ▫ If so, when and where? _____

III. WORK STATUS

Is the employee currently working? ▫Yes ▫No

Does the employee have work restrictions? ▫Yes ▫No

- ▫ If yes, please fax a copy of the work restrictions to RTW, Inc. at 800-563-3364.

Has work been offered to employee within restrictions? ▫Yes ▫No

- ▫ If yes and a written job offer has been completed, please fax a copy to RTW, Inc. at 800-563-3364.

IV. OTHER

Are there any concerns or issues with the employee or with the nature of the injury? ▫Yes ▫No

Additional comments: