Employee Injury Report

IMPORTANT:
Your claim for benefits cannot be fully processed until your questionnaire is returned.

Last Name First Name MI	Birth Date	SSN:	Sex: ___M ___F	Marital Status ___Single ___Married	# of Children under 21
	___/___/___	___-___-___			

PO Box/Street Address/City/St/Zip	Phone#:

Where were you hired?	Length of time employed:

Date of Injury (mm/dd/yy)	Date you first reported injury:	Name and Title of Person you reported to:
___/___/___ Time: ___:___ AM PM (circle one)	___/___/___	

Where were you when injury occurred?	Describe how and what happened to cause this injury:

Witnesses, Names and Address:

1. _____
2. _____

Note all injuries from this accident: (you must be complete)

Was your injury the result of someone else's negligence? ☐ Yes ☐ No

If yes: Name: _____ Address: _____ Phone: _____

Insurance Co.: _____ Policy or Claim No.: _____

Name and Addresses of all doctors and hospitals treating you:

1. _____
2. _____
3. _____

Date of first medical treatment:	Date of most recent treatment:	Are you still under doctor's care?	Are you working?
___/___/___	___/___/___	☐ Yes ☐ No	☐ Yes ☐ No

Did you miss work?	Dates of lost time:	Were you paid for any part of time lost?	**TRUCKING QUESTION ONLY:** Where did your Employer/Company administer your Qualification Tests?
☐ Yes ☐ No		☐ Yes ☐ No	(City & State) City _____ State _____

At the time of your injury, were you employed anywhere else? ☐ Yes ☐ No

If Yes: Name: _____ Address: _____ Duties: _____

Have you had previous problems or treatments to this body area or areas? ☐ Yes ☐ No
If so, please describe and include the dates you experienced the problems or treatments.

1. _____
2. _____
3. _____

Have you ever suffered any injuries either work or non-work related before? ☐ Yes ☐ No If so please explain:	Have you ever filed a Workers' Compensation claim? ☐ Yes ☐ No When: _____ Where: _____

Name and address of your former employers:	Please list name and address of your group health insurance:
1. _____ 2. _____ 3. _____	

Name and Address of your family physician:	Are you covered by your spouse's health insurance? ☐ Yes ☐ No

Employee Signature:	Date: