KASB
Workers Compensation Fund, Inc.

REPORT BY INJURED EMPLOYEE

Employer:_____

Your Name:_____

Your Home Address:_____

Your Home Phone Number:_____

Social Security Number:_____

Date of Accident:_____Time of Accident: _____ Building/Facility: _____

In your own words, please describe what happened:_____

_____

_____

_____

What physical problems do you relate to this injury?_____

_____

_____

Did you report this injury to your supervisor?_____If not, why not?_____

Date Reported?_____Supervisor's Name:_____

Were you working at your regular job at the time of the injury?_____If not, please explain:

_____

_____

_____

Were there any witnesses?_____If yes, who?_____

_____

Did you go to a hospital/clinic? Yes☐ No☐

Address of hospital/clinic:_____

Name of treating physician:_____

Any additional comments:_____

_____

_____ _____

Date Signature