

CCMSI

EMPLOYEE'S REPORT OF INJURY

Name _____ Claim # _____

Address _____

Occupation _____ Date of Birth _____ Soc. Sec. # _____

Sex _____ Married or Single _____ Employer _____

Employer's Address _____

Department _____ No. days/per week _____ Normal days off _____

Length of employment _____ Wages (hourly rate of pay) _____ Number hours worked/day _____

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. _____

Date of injury _____ Time _____ Date injury reported _____

Accident reported to _____ By (name) _____

Who witnessed accident? _____

(Name & Address) _____

Describe fully how injury happened _____

(Continue on back if necessary)

What part(s) of your body were injured? _____

Did you stop work as a result of your accident? Yes No When? _____

Was your pay continued during any part of your disability? _____

If so, for what period? _____ Last day for which you were paid _____

If not working when do you expect to return to work? _____ If you did return what was the date? _____

From whom did you receive first medical treatment? _____ Date of treatment _____

Are you still under medical treatment? _____ How often do you receive treatment? _____

Name of doctor treating you _____

Address of doctor _____ Phone # _____

Signature _____ Date _____

Claim # _____