CIRMA Injury Reporting Information

Fax Form to HR Office at 860-294-0263 or scan and e-mail to HR@torrington.org

Event Date/Time

Incident Date and Time: ______________________ Employer Notified: ______________

Reporter & Location Information

Reported by: ____________________________ Title: ______ Phone Number: ________

Location Code: __________ Location Name: ____________ Address: ______________

Claimant Information

Social Security Number of Claimant: ____

Claimant Name: ____

Home Phone: ___________________________ Work Phone: ____________________

Home Street Address: ____

City: ____________________ State: __________ Zip: ______________________

Date of Birth: __________ Marital Status: ________ Gender: ☐ Male ☐ Female

Employment

Job Title: _________________ Status: _______________

Claimant's Supervisor: _______________________ Title: __________ Phone: ________

Incident

Description of the Injury: ____

____

Cause: _________________________________ Body Part: ______________________

Nature Code: ____

Medical Provider (if known): __________________ Address of Medical Provider: ________

Name of Doctor (if known): ____

Witness Name (if any): ____

Lost time from work (if known): ______________ Return to work date: _____________

Loss Location Entity: ____

Address: ____

Contact Person: ____

Additional Information

Job Classification code: ____

Time the employee began work on the day of injury: ______________________________

Supervisor Notice Date: _______________________ Claim Incident Number: [ ]

This is assigned by NetClaim.net (at the FINISH tab) or by the Hotline operator.

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