



EMPLOYEE'S REPORT OF INJURY

EMPLOYEE DATA

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ GENDER _____
FULL NAME _____ PHONE _____
ADDRESS _____ WORK LOCATION _____

INJURY/MEDICAL DATA

LOSS DATE _____ DATE EMPLOYER NOTIFIED BY EMPLOYEE _____
WORKSITE LOCATION OF INJURY _____
TIME EMPLOYEE BEGAN WORK _____ TIME OF EVENT _____
Is the employee seasonal? ☐ YES ☐ NO
Did the employee die? ☐ YES ☐ NO
Will the employee miss more than 7 days of work? ☐ YES ☐ NO
How did the injury occur? _____

BODY PART(S) INJURED _____

OCCUPATIONAL AND WAGE DATA

OCCUPATION _____ HIRE DATE _____
Pay rate: _____ ☐ HOURLY ☐ SALARY
Was medical treatment sought? ☐ YES ☐ NO
Where was medical treatment sought? _____

PREPARER INFORMATION

FULL NAME _____ PHONE _____
EMAIL _____ COMPANY NAME _____

SIGNATURE

SIGNATURE _____ DATE _____ CLAIM # _____