



## EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ <small style="margin-left: 40px;">Last                      First                      MI                      Maiden</small> Address: _____ City: _____ State: _____ Primary Phone Number: _____ Secondary Phone Number: _____ Email address: _____	Social Security: _____ Gender: M / F Date of Injury: _____ Employer: _____ Job Title: _____ Work Schedule: _____
1) What was the exact location of the accident (street address if possible):	
2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)	
3) Briefly describe what exactly caused the injury:	
4) What areas of your body were injured?	
5) When and to whom did you report your injury?                      Date _____ Time _____ Name: _____ Title _____ Phone Number: _____	
6) List all known witnesses. (Continue on back if necessary)    Name _____ Phone: _____ Name _____ Phone: _____    Name: _____ Phone: _____	
7) Please identify your Primary Care Physician or family doctor: Name: _____ Phone: _____	
8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury: Name: _____ Phone: _____ Name: _____ Phone: _____ Name: _____ Phone: _____	
9) Has a doctor taken you off work? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If so, when was the first day you missed work ? _____	
10) If the doctor took you off work, have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If not, when do you think you will return to work? _____	
11) Date of Last Appointment: _____                      11) Date of Next Appointment: _____	
12) Have you had previous workers compensation injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, please enter dates of injuries and the body parts injured.	
By affixing my signature, I attest that all information on this form is accurate and true.	
Signature: _____ Date: _____	