WORKERS COMPENSATION INJURY REPORT

NAME:_____ PHONE:_____

ADDRESS:_____ SSN #:_____

CITY:_____ STATE:_____ ZIP:_____ BIRTH DATE:_____

MALE:_____ FEMALE:_____

PRESENT EMPLOYER:_____ If injury occurred employed elsewhere:

Address:_____ Employer:_____

City:_____ State:_____ Zip:_____ Address:_____

Date Employed:_____ City:_____St:____Zip_____

Your Occupation:_____ Dates employed:_____

Employer Contact for Workers' Comp Claims: Occupation:_____

Name:_____ WC Contact:_____

Telephone:_____ Phone:_____

***** ***** ***** ***** ***** ***** *****

Accident Date:_____ Time:_____

Date and time disability began:_____

What date and time did you first leave work?_____

How long have you been off work?_____

Where did the accident take place?_____

Does your employer know about this accident?_____

When did you report it?_____

Have you seen any other doctors about this?_____

If yes, list doctors' names:_____

If yes, was this a company doctor?_____ private doctor?_____

If yes, did you receive permission to change doctors?_____

If yes, do you have a referral from the doctor?_____

If yes, what was the diagnosis?_____

If yes, what treatment did you receive?_____

_____

Have you made a report to anyone else?_____ Whom?_____

Did you obtain permission from your employer to see a doctor?_____

Are you filing a claim under State of Federal Compensation Acts?_____

Explain briefly how this accident happened:

Describe your symptoms in detail:

Have you ever had similar problems before?_____ If yes, give complete details including dates and names of doctors:

Date:_____ Your Signature:_____