

# EMPLOYEE'S REPORT OF INJURY

## PERSONAL INFORMATION

NAME	CLAIM #	
ADDRESS	HOME PHONE	CELL PHONE
Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
OCCUPATION	EMPLOYER	DEPARTMENT
EMPLOYER ADDRESS		
NUMBER OF DAYS PER WEEK	NUMBER OF HOURS PER DAY	NORMAL DAYS OFF
LENGTH OF EMPLOYMENT	WAGES (HOURLY RATE OF PAY)	

## INJURY INFORMATION

DATE OF INJURY	TIME	DATE INJURY REPORTED
Accident reported to: _____	By (name): _____	
Who witnessed accident (name & address for each person listed)? _____		
Describe fully how injury happened (continue on back if necessary): _____		
What part(s) of your body was injured? _____		
Did you stop work as a result of your accident? <input type="checkbox"/> YES <input type="checkbox"/> NO When: _____		
Was your pay continued during any part of your disability? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If so, for what period? _____ Last day for which you were paid? _____		
If not working, date you expect to return to work? _____ If you did return to work, list date? _____		
From whom did you receive first medical treatment (list date)? _____		
Are you still under medical treatment? _____ How often do you receive treatment? _____		
NAME OF DOCTOR	ADDRESS	PHONE

## SIGNATURE

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ CLAIM # \_\_\_\_\_