Workers' Compensation Injury Reporting Form

Contact 800-367-3743 to Report Claim

Reporter Name: ______________________ Phone #: __________

Policyholder Name: ______________________ Policy #: __________

Date of Injury: ________ Time of Injury: ________ ☐ AM ☐ PM (check one) NAICS Code (if unknown, leave blank): ________

Employer's contact name and job title: ______________________

Contact numbers: Work #: __________ Fax #: __________ Secondary #: __________

Email Address: ______________________

Name of injured employee (Please use full legal given name): ☐ Male ☐ Female (check one)

First: __________ Middle initial: ___ Last: __________

Address of injured employee:

Street: ______________________

City: __________ State: _____ Zip Code: __________

County: __________

Phone number for employee: __________ ☐ Home ☐ Cell

Employee's Social Security # __________ Date of Birth __________

Dependent children under 18: __________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed (check one)

Date of Hire: __________ Occupation: __________

Address where injury happened: (Please name street, city, state, zip and county)

Street: ______________________

City: __________ State: _____ Zip Code: __________

County: __________

Date Employer notified of injury to Employee: __________ On Employer Premises? ☐ Yes ☐ No (check one)

Describe the injury and how the injury occurred: (list body part injured and which side, right or left)

Cause of Injury

Detailed Injury Type

Area of Body

Was there a witness? ☐ Yes ☐ No If Yes, what is their name and phone number? __________

Is the employee: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Other (check one)

Employees normal start time of day: __________ ☐ AM ☐ PM (check one)

Paid for the day of injury? ☐ YES ☐ NO Employee expected to miss more than ☐ 3 days ☐ 7 days

Did employee lose time from work? ☐ YES ☐ NO

How many **days** a week does the employee work: __________

Average weekly wage of employee: $ __________

List where Employee sought treatment:

Name of Doctor or Hospital: ______________________

Address: ______________________

City: __________ State: _____ Zip Code: __________

Phone number for Doctor or Hospital: __________

Is a language interpreter needed? ☐ YES ☐ NO If YES, what language is preferred? __________