

You are responsible for answering all questions on the **Employee's Work Injury Report** accurately and in detail. This will make the processing of your claim both accurate and timely. This completed report should be given to the workers' compensation contact within 24 hours of your work-related injury

Employee's Work Injury Report

Personal	Name _____ Social Security Number _____
	Address _____ Birth Date _____ Sex M <input type="checkbox"/> F <input type="checkbox"/>
	City, State _____ Zip _____ Telephone _____
	Married <input type="checkbox"/> Single <input type="checkbox"/> Number of Dependents _____ Home/School _____
	Family Physician _____ Telephone Number _____
	Are you currently entitled to Medicare Benefits? N <input type="checkbox"/> Y <input type="checkbox"/> Medicare #(HICN) _____
	Have you applied for Medicare or SSDI? N <input type="checkbox"/> Y <input type="checkbox"/> Pending <input type="checkbox"/> Rejected <input type="checkbox"/>
Employment	Job Title _____ Employment Date _____
	Salary/Hourly Rate _____ Hours Worked Per Day _____
	Building Location _____ Time Work Day Begins _____
Injury/Illness	Date of Injury _____ Time of Accident _____
	Where in the facility/job site did this injury occur? _____
	What were you doing when injured? _____
	How did the injury occur? _____
	Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.) _____

	Any previous similar injury? If yes, explain. _____
	Was this injury witnessed? If so, by whom? _____
	Did you lose time from work? Yes <input type="checkbox"/> No <input type="checkbox"/> Date(s) missed _____
	Have you returned? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the date? _____
Treatment	Medical Facility _____
	Diagnosis/Care Prescribed _____
Contact	When you return to work, you must call _____
	Employee's Signature (PRINTED) _____ Date _____
	Employee's Signature _____