

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 _____	