

Workers' Compensation Phone Reporting Form

EMPLOYER

Carrier: _____ **Phone:** (800) _____
Policy No.: _____
Insured: _____
Address: _____
Contact Person: _____ **Phone** _____ **Fax** _____
Type of Employer: (check one) Private State County City School Dist. Other - Specify _____
Nature of Business: _____
State Unemployment Insurance Account No.: _____

INJURY OR ILLNESS INFORMATION

7. Date of Injury: _____ 8. Time of Injury: ____ am/pm 9. Time employee began work: ____ am/pm
10. Employee Die? Yes No, Date of Death: _____
11. Employee unable to return to work at least 1 full day after injury? Yes No
12. Date employee last worked: _____ 13. Date employee returned to work: _____ 14. Still off work Yes No
15. Employee paid full wages for date of injury or last day worked? Yes No
16. Salary being continued? Yes No 17. Date of knowledge of injury: _____
18. Date employee provided with claim form _____
19. Specific injury/illness and medical diagnosis: _____
19a. Body Part affected: _____
20. Location of event: _____
Address City State Zip
21. On employer premises: Yes No 21a. Was another person responsible? Yes No
22. Department where event took place: _____ 23. Other workers injured Yes No
24. Equipment, material and chemicals the employee was using when the injury occurred: _____

25. Specific activity the employee was doing when event occurred: _____
26. How did injury occur, describe sequence of events: _____

27. Name of Physician: _____ Phone: (____) _____
Address: _____
28. Employee hospitalized as inpatient overnight? Yes No
Hospital name: _____ Phone: (____) _____
Address: _____
29. Employee treated in Emergency Room? Yes No

EMPLOYEE

30. Employee name: _____ 31. SS#: _____ 32. Date of Birth: _____
33. Home address: _____
33a. Phone (____) _____ 34. Sex: Male Female 35. Occupation: _____
36. Date of Hire: _____ 37. Employee usually works: ____ hr/day ____ days/week ____ Total hr/wk
37. Employee Status: (Check one) Disabled Unemployed Regular, Full-time Part-time Retired On strike Temporary
 Seasonal Laid-off Other: _____
37b. Workers Compensation Class Code of Injured employee: _____ 38. Gross wages/salary \$ ____ / ____
39. Other payment not reported as wages/salary (e.g. tips, meals, overtime) Yes No

Claim called in on what date: _____ Name of representative talked to: _____

Supervisor's Injury Report

Employee Name: _____ Date : _____

Where did the accident happen: _____ Machine No.: _____

What was the employee doing at the time of the accident: _____

How did the accident happen: _____

Object or substance that injured the employee: _____

Nature of Injury: (Check one)

- | | | | | | |
|-------------------------------------|---|--------------------------------------|-------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Burn (heat) | <input type="checkbox"/> Burn (Chem) | <input type="checkbox"/> Concussion | <input type="checkbox"/> Crushing | <input type="checkbox"/> Cut |
| <input type="checkbox"/> Puncture | <input type="checkbox"/> Occup. Illness | <input type="checkbox"/> Bruise | <input type="checkbox"/> Fracture | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Strain | <input type="checkbox"/> Other: describe) _____ | | | | |

Part of Body: (Check one) Right Left

- | | | | | | |
|--------------------------------|-------------------------------|-----------------------------------|--------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Eye | <input type="checkbox"/> Head | <input type="checkbox"/> Face | <input type="checkbox"/> Neck | <input type="checkbox"/> Back | <input type="checkbox"/> Trunk |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Hand | <input type="checkbox"/> Wrist | <input type="checkbox"/> Finger | <input type="checkbox"/> Leg | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Toe | <input type="checkbox"/> Internal | <input type="checkbox"/> Multi-parts | <input type="checkbox"/> Other: describe) _____ | |

Employee sent to Doctor: Yes No if yes DOCTOR: _____

Date of Injury: _____ Time: _____ (am/pm) Lost time Yes No

Supervisor's Accident Investigation Report

Years of Service: _____ Time on present Job: _____ Title/Occupation: _____

Unsafe mechanical/physical/environmental conditions at the time of the accident? (Be specific) _____

Unsafe act by injured and/or others contributing to the accident? _____

Personal Factors that contributed to accident: (attitude, fatigue, training?) _____

Personal protective equipment required? (list) _____

Was injured employee using the required equipment at the time of the injury? Yes No

Witness to Accident (list Names): _____

What do you suggest be done to prevent a similar accident? _____

What action have you taken? _____

COMPLETED BY: _____