

WORKERS' COMPENSATION CLAIM REPORT FORM

EMPLOYER INFORMATION			
EMPLOYER NAME		FEDERAL TAX ID	D/B/A NAME
ADDRESS		ADDRESS	
CITY	STATE	ZIP	CITY
COUNTY		SIC/NAICS CODE	STATE ZIP
		LOCATION CODE	
EMPLOYEE INFORMATION			
FIRST NAME	MIDDLE NAME	LAST NAME	EMPLOYEE SOCIAL SECURITY #
ADDRESS			Employee HOME PHONE NO.
CITY			Employee CELL PHONE NO.
CITY	STATE	ZIP	DATE OF BIRTH
COUNTY		OFFICER / PARTNER	DATE OF HIRE
		<input type="checkbox"/> YES <input type="checkbox"/> NO	STATE OF HIRE
REGULAR DEPARTMENT OR DIVISION		OCCUPATION OR JOB TITLE	EMPLOYEE'S PAY RATE (PER HOUR)
SUPERVISORS NAME		IS THIS A QUESTIONABLE CASE	AVERAGE DAYS WORKED PER WEEK
		YES NO	AVERAGE HOURS WORKED PER DAY
			EMPLOYMENT STATUS (FT/PT)
ACCIDENT INFORMATION			
PLACE OF ACCIDENT OR OCCURRENCE		DATE OF INJURY / ILLNESS	DID EMPLOYEE LOSE ONE OR MORE DAYS OF WORK?
CITY	STATE		<input type="checkbox"/> YES
COUNTY OF INJURY	FILING STATE	TIME OF OCCURRENCE	LAST DATE WORKED
EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		AM <input type="checkbox"/> PM <input type="checkbox"/>	FIRST DATE OF DISABILITY
		TIME WORKDAY BEGAN	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		AM <input type="checkbox"/> PM <input type="checkbox"/>	DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
DATE EMPLOYER NOTIFIED		DID EMPLOYEE RETURN TO WORK:	<input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
NAME OF PERSON NOTIFIED		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	DATE
CONTACT PERSON NAME			
CONTACT PERSON PHONE			
DESCRIPTION OF ACCIDENT			
NATURE OF INJURY OR ILLNESS IN DETAIL (Include exact part of body affected, e.g., strain to lower back, fractured left arm, lead poisoning.)			
CAUSE OF INJURY INCLUDING EMPLOYEE'S WORK ACTIVITY AT TIME OF INJURY (e.g., loading truck, typing, assembling product)			
FATALITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		WERE THEY USED?
DATE OF DEATH	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
MEDICAL INFORMATION			
SELECT TYPE OF TREATMENT	<input type="checkbox"/> NO MEDICAL TREATMENT	FACILITY NAME	TELEPHONE
	<input type="checkbox"/> FIRST-AID/IN-HOUSE	ADDRESS	
	<input type="checkbox"/> OCC HEALTH CTR/PANEL DR		PHYSICIAN'S NAME
	<input type="checkbox"/> EMERGENCY ROOM	CITY	
	<input type="checkbox"/> HOSPITALIZED	STATE	ZIP
	<input type="checkbox"/> UNKNOWN		
WITNESSES (NAME & PHONE NO.) _____			
DATE	REPORTED BY	PHONE	