EMPLOYEE INFORMATION

First Name:

Last Name:

Job Title:

Telephone:

Street Address:

City:

State:

Zip Code:

County:

Social Security Number:

Sex:

Marital Status:

Number of Dependents:

Date of Birth:

Date of Hire:

Employment Status:

INCIDENT INFORMATION

Date of Injury:

Time Employee Began Work:

Time of Occurrence:

Last Day Worked:

Date Disability Began:

Full Pay For Day of Injury:

Date Employer Notified:

Date Returned To Work:

Type of Injury or Illness:

Parts of Body Affected:

Cause of Injury:

Did injury or illness occur on employer's premises?

Were safeguards or safety equipment provided?

Were safeguards or safety equipment used?

If out of state, specify state of injury:

How injury or illness /abnormal health condition occurred:

Describe the sequence of events and include any objects or substances directly responsible:

Did accident/illness result in fatality:

EMPLOYER INFORMATION

Employer Name:

Contact First Name:

Last Name:

Contact Telephone: Street Address:

City:

State:

Zip Code:

County:

Telephone:

Employer FEIN:

Policy Number:

Policy Period From:

Policy Period To:

INITIAL TREATMENT INFORMATION

Hospital Name:

Doctor First Name:

Lat Name:

Telephone: