



## Report of Injury

Employer's Name and Address		Date
City, State, ZIP, County		Emp. Phone
Injured Worker's Last Name, First Name, Middle Initial		Recur/New Injury Date
Home Street Address		Home Phone No.
City, State, ZIP, County		Marital Status Time Work Began <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Social Security Number	Date of Birth	Date of Hire
Occupation		
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	If Part-Time, Days Worked <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun	Name of Other Employer
Hourly Rate	Supervisor	Supervisor Number
Date of Incident	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date Reported Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Did incident occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Where:		
Performing regular job at the time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Losing time? <input type="checkbox"/> Yes <input type="checkbox"/> No Last day worked:		
Description of incident (who, what, when, where, how, and why):		
List of body parts injured:		
Prior injuries and with what employer:		
Treatment sought and with whom:		
Name and phone number of witnesses:		
Remarks:		
Reported by:	Date:	Time:

**Fraud Statement:** Any person who knowingly and with intent to defraud any insurance company, or files an application for insurance or statement of claim containing any material false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects the person to criminal and civil penalties.

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