

WORK RELATED INJURY REPORT

Name of Injured Worker: _____

Date injury occurred: _____ Time injury occurred: _____

Employer: _____

Employer Phone Number: _____

Name and phone number of person we can contact regarding this work injury:

City and State where injury occurred: _____

Job Title/Activity: _____

Type of work being done at time of injury: _____

Please describe how your work injury occurred:

What was injured?

Have you injured this before? _____ When: _____ How? _____

List any equipment, machinery and/or object related to the accident: _____

Was the accident reported to your supervisor or employer? Yes No If so, to whom _____

Has a Worker's Compensation claim been filed? Yes No

Insurance Carrier _____ Claim #: _____

Insurance contact person: _____ Insurance phone number: _____

Length of time you have worked there prior to accident: _____

Have you ever filed a worker's compensation claim for a different injury? Yes No

Have you done any work since your work related injury? Dates: _____

Signature: _____ Date: _____