WORKERS COMPENSATION REPORTING WORKSHEET

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER MALE FEMALE
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS	DOES THE EMPLOYEE SPEAK ENGLISH? (Yes) (No)
EMPLOYEE'S HOME PHONE NUMBER ( ) EMPLOYEE'S CELL PHONE NUMBER ( )	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS
SUPERVISOR'S NAME:	SUPERVISOR'S EMAIL ADDRESS:	

ACCIDENT INFORMATION

ACCIDENT LOCATION_____

DATE OF INJURY_____

TIME OF INJURY_____

WHAT TIME DID YOU START WORK_____

WERE YOU USING SAFETY EQUIPMENT YES NO

WHAT WERE YOU DOING AT THE TIME OF INJURY?
Please explain:

CAUSE OF ACCIDENT: SLIP/FALL, LIFTING, CHEMICAL, OTHER
Please explain:

PART OF BODY INJURED: HEAD, NECK, ARM, LEG, BACK, OTHER
Please explain:

NATURE OF INJURY: FRACTURE, SPRAIN, LACERATION, OTHER
Please explain:

WHAT KIND OF TREATMENT DID YOU HAVE?

None First-aid Work comp Doctor Emergency room

WITNESS_____
Name phone #

WITNESS_____
Name phone #