Workers' Compensation
Employee Information

Employee's Full Name: ____

Employee's Address: ____

Phone Number: ______________________ Work Phone Number: _____________________

Email Address: ________________________________

Date of Birth: _________ Marital Status: _______ # of Dependents Children: __________

Employee's Social Security Number: ________________________

Date of injury: __________________ Time of injury: ____________ a.m./p.m.

Address of location where injury occurred: ____

What was Employee doing when the accident occurred? ______________________________

____

Part of the body affected (be specific): ____

How did accident or illness occur? ____

____

____

Have medical services been rendered to the Employee? _____ Yes _____ No

Did Employee go to the Emergency Room? _____Yes _____No

Is or has the Employee been hospitalized? ______ Yes ______ No

Name and address of physician: ____

____

Name and address of hospital: ____

____

Has Employee lost workdays? ______ Yes ______ No Date(s) _______________________

Report prepared by: ________________________________ Date: ___________________