

Employee's Report of Injury

Step 1: Please complete and submit no matter how minor the injury.

Last Name:	First Name:	M.I.	SSN:
Street Address:			Apt.
City:		State:	Zip:
Phone Number:	Email Address:		Date of Birth:
Employer:	Job Title:	Department:	
Injury Reported To:	Position:	Date Reported:	
Date of Injury:	Last Day Worked:	Return to Work Date:	

Where did the injury occur?

What were you doing when the injury occurred?

How did the injury occur?

What object or substance caused the injury?

Type of Injury:	Part of Body:
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What type of treatment was received?

Who witnessed the accident?

Was the injury caused by someone else?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Name:

Did the accident involve employees or equipment from another company?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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What actions (if any) were taken to prevent similar accidents from occurring?

Have you had a Workers' Comp claim in the last year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If Yes, When:

Have you had a previous injury to this body part?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If Yes, When:

Department:	Job title at time of incident:	
Are you currently going to physical therapy?	Work schedule:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Regular Full-Time	<input type="checkbox"/> Regular Part-Time
Are you taking pain medication?	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Temporary
<input type="checkbox"/> Yes <input type="checkbox"/> No	Months with this employer:	
Are you taking any other medications?	Months doing this job:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		

If yes, please list all medications:

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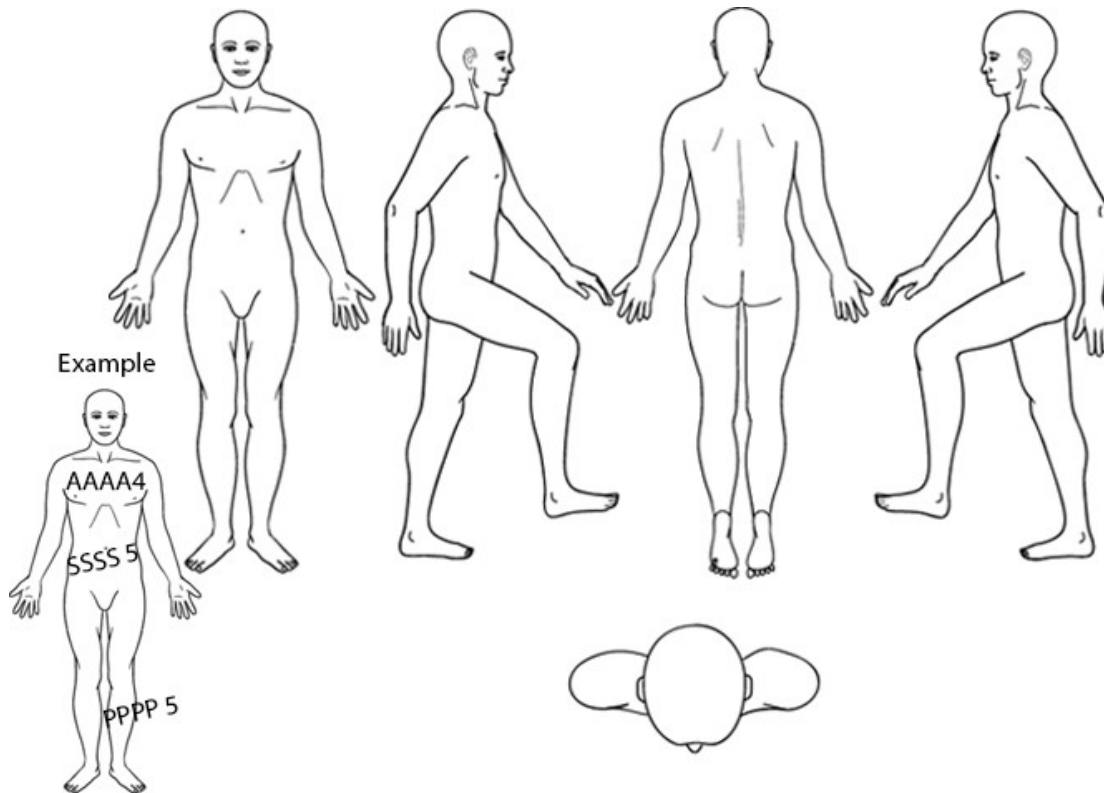
Step 2: Pain chart.

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol	NNNN	PPPP	BBBB	AAAA	SSSS

Nature of injury: (most serious one)

<input type="checkbox"/> Abrasion, scrapes	<input type="checkbox"/> Amputation	<input type="checkbox"/> Broken bone	<input type="checkbox"/> Bruise
<input type="checkbox"/> Burn (heat)	<input type="checkbox"/> Burn (chemical)	<input type="checkbox"/> Concussion (to the head)	<input type="checkbox"/> Crushing Injury
<input type="checkbox"/> Cut, laceration, puncture	<input type="checkbox"/> Hernia	<input type="checkbox"/> Illness	<input type="checkbox"/> Sprain, strain
<input type="checkbox"/> Damage to a body system: (e.g. nervous, respiratory, or circulatory system):			
<input type="checkbox"/> Other:			



Note: Any person who knowingly provides false, incomplete, or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.

Employee Name (print) _____

Employee Signature _____

Date _____

Please fax completed form to (480) 289-6220 or email to WCNewClaims@InsuredSolutions.net.