Work Injury Report

NAME: _____ **DATE:** _____ / _____ / _____

DATE OF INCIDENT: _____ / _____ / _____

Who is Your Employer? _____

Employer's Address: _____

Employer's Phone: _____ Fax: _____

Your Occupation/ Job Title: _____

Please list your regular job duties and/or what is expected from you:

_____

_____

_____

Insurance Company:_____ Incident Reported to Ins. Co.? **Yes / No**

Claim Adjuster's Name: _____ Claim#: _____

Address of Insurance Company:_____

Phone: _____ Adjuster's Email: _____

Brief Description of the Incident: *Please use the back of this form, if necessary.*

_____

_____

_____

_____

_____

Location of Incident: _____ **Time:** _____ **: _____ am pm**

Reported to Employer? **Yes / No** Currently Working? **Yes / No** Last Day Worked: _____ / _____ / _____

Did You Hit Your Head? **Yes / No** Did You Lose Consciousness? **Yes / No** How Long? _____
Did You Injure Any Body Parts? **Yes / No** Where? _____
Did You Immediately Experience Pain? **Yes / No** Where? _____

Who was at the Scene? **Co-Worker Ambulance Other:** _____
Did You Go to a Hospital After the Incident? **Yes / No** Where?_____
Tests Performed at the Hospital? **Yes / No** Which? _____
Medications Prescribed? **Yes / No** What? _____
Diagnosis Explained to You? **Yes / No** Explain: _____
Any Other Doctors Seen for this Injury? **Yes / No** Who? _____

Do you have an attorney? Yes No **Attorney's Name:** _____

Have you had any other work injuries, car accidents, or slip/falls within the past 5 years? Yes No

"This incident has reduced my capacity to work by (Please estimate a %)**: _____ %."**

Signature: _____ **Date:** _____ / _____ / _____