

**Accident/Worker's Compensation Form**

SS # \_\_\_\_\_ Date: \_\_\_\_\_

Employee: \_\_\_\_\_ Employee Phone/Cell: \_\_\_\_\_  
(Best # for Insurance Nurse/Carrier to contact you)

Address: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Hired: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employee Status: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Last Work Date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time Employee Started Work: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

Did injury occur on Employer's premises? \_\_\_\_\_

Describe the Injury/Illness (Briefly describe the nature of the injury or illness; eg. Lacerations to forearm) \_\_\_\_\_

Part of body affected (Indicate the part of the body affected by the injury/illness; eg. Right forearm, lowerback) \_\_\_\_\_

How Injury/Illness Occurred (Describe the sequence of events and include any objects or substances that directly injured you or made you ill) \_\_\_\_\_

Medical Treatment: No Medical Treatment \_\_\_\_\_ First Aid by Employer/Employee \_\_\_\_\_  
Minor Clinic/Hospital \_\_\_\_\_ Emergency Care \_\_\_\_\_

Name of Witness to Injury (if applicable): \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Employee Signature: \_\_\_\_\_