REPORT OF EMPLOYEE'S INJURY

EMPLOYER'S NAME _____ SELF-INSURED # SI 3119-00

_____ _____

ADDRESS CITY/STATE/ZIP CODE

EMPLOYEE NAME _____ OCCUPATION _____

_____ _____

ADDRESS CITY/STATE/ZIP CODE

DATE OF HIRE _____

DATE OF INJURY _____ TIME OF INJURY _____ AM _____ PM

DATE REPORTED TO EMPLOYER _____

WITNESSES (If any) _____

_____

ACCIDENT LOCATION IF DIFFERENT FROM COMPANY LOCATION:

_____ _____

ADDRESS CITY/STATE/ZIP CODE

DESCRIPTION OF ACCIDENT (Describe in Detail):

_____

_____

GIVE THE EXACT NATURE OF INJURY AND PART OF BODY AFFECTED (e.g., fracture of right hand, etc.):

_____

_____

WAS EMPLOYEE TREATED AT WORK ☐ YES ☐ NO

DID EMPLOYEE RECEIVE OUTSIDE MEDICAL TREATMENT ☐ YES ☐ NO

GIVE NAME OF HOSPITAL, CLINIC, AND/OR PHYSICIAN'S NAME _____

LOST TIME FROM WORK ☐ YES ☐ NO

LAST DATE WORKED _____ RETURN TO WORK (if known) _____

DID THE INURY RESULT IN DEATH? ☐ YES ☐ NO FULL/PART TIME _____

SALARY/WAGES CONTINUED ☐ YES ☐ NO

SIGNING THIS REPORT DOES NOT CONSITUTE CERTIFICATION OF AN INDUSTRIAL CLAIM

_____ _____

EMPLOYEE'S SIGNATURE EMPLOYER'S SIGNATURE

_____ _____

DATE TITLE

_____

DATE