Workers Compensation Incident Report Form

If you are involved in a work related accident, please use this card to provide the details of the injury. This information is necessary for reporting a claim with the carrier and will help speed up the handling process. For expedited service, please call the insurance carrier to report the accident directly. Their contact information can be found on the insurance policy you received upon issuance.

EMPLOYEE INFORMATION

Name of employee:_____
First Middle Last
Employee contact #:___(_____)_____
Hire date:_____
Social security #:_____
Hourly wage:_____
Is employee full time/part time:_____
Supervisor name:_____ Supervisor ph#:_____

INCIDENT INFORMATION

Date of accident:_____
Returned to work? ☐ Yes / ☐ No ☐ Full / ☐ Light Duty Date expected to return:_____
What part of your body was injured:_____
Location of accident:_____
Street City State Zip
Did employee seek medical treatment: ☐ Yes / ☐ No
Name and address of medical facility treating patient:_____
Name of physician:_____
What type of treatment are you receiving:_____

Description of occurrence:

_____
_____
_____
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_____
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_____

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