



# Workers' Compensation Claim Reporting Guide

Name of person reporting:

For report only  
 Yes  No

## Address Information

Name and address information of the company

Policy Number

Site Code (if applicable)

Contact Name

Telephone number of loss location

## Accident information

Date of accident

Time of accident  
 Am / Pm

Address of where incident occurred

Please give a description of incident:

Were authorities contacted? (police, fire, ambulance)  
 Yes  No

If yes, who?

Was a report number given?  
 Yes  No

If yes, list number

Were any safeguards provided?  
 Yes  No

Were they in use at the time of the incident?  
 Yes  No

In the event of a fatality, what is your OSHA number?

## Claimant information

What is the name and address of the injured party?

Home Phone

Contact at Home or Work  
 Home  Work

Work Phone

Is the injured party  
 Male  Female

Social Security Number

Date of Birth

Marital status (check one)  
 Single  Divorced  
 Separated  Married  
 Widowed

How Many Dependents

Regular occupation

Occupation performed at time of incident

If fatality, what date did it occur

## Employment information

Employment status (check one)

- Full-time     Temporary     Contract     On-call  
 Part-time     Seasonal     Retired     Volunteer

Date of hire

Hours worked per day

Days worked per week

Was there time lost?

- Yes     No

Paid thru date

Eligible for salary continuation

(Sick leave, Short-term disability)

- Yes     No

Date disability began

Last day worked

Date returned to work  
or expected date

Hourly or weekly wage

 H W

Wage Listed

- Actual     Estimate

Employee is eligible for (check one)

- Bonus     Overtime  
 Tips     Commissions

Weeks worked in last twelve months

Employer notified on what date

## Injury information

Were any injuries incurred?

- Yes     No

What part of the body?

What treatment was given (please check)

- No Medical Treatment  
 Minor on-site remedies  
 Minor clinic or hospital  
 Emergency evaluation  
 Hospitalization for more than 24 hours

Give a description of the injuries

Name and address of treating physician

Name and address of treating hospital/clinic

Phone number of treating physician

Phone number of treating hospital/clinic

## Witness information

Name and address of a witness to the incident

Phone number where witness can be reached

Anything related to the incident that you would like to add

**Please fax the completed form to: 602-778-9857**  
**Remember to report all injuries immediately**