



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: **602-386-3582**

Remember to report all injuries immediately