workpartners

Report of Injury

Employer's Name and Address			Date
City, State, ZIP, County			Emp. Phone
Injured Worker's Last Name, First Name, Middle Initial			Recur/New Injury Date
Home Street Address			Home Phone No.
City, State, ZIP, County Marital Status			Time Work Began ☐ a.m. ☐ p.m.
Email Address			
Social Security Number		Date of Birth	Date of Hire
Occupation			
☐ Full-time ☐ Part-time	If Part-Time, Days Worked ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun		Name of Other Employer
Hourly Rate	Supervisor		Supervisor Number
Date of Incident	Time ☐ a.m. ☐ p.m.	Date Reported	Time ☐ a.m. ☐ p.m.
Did incident occur on employer's premises? ☐ Yes ☐ No Where:			
Performing regular job at the time of incident? ☐ Yes ☐ No			
Losing time? ☐ Yes ☐ No Last day worked:			
Description of incident (who, what, when, where, how, and why):			
List of body parts injured:			
Prior injuries and with what employer:			
Treatment sought and with whom:			
Name and phone number of witnesses:			
Remarks:			
Reported by: Date: Time:			

Fraud Statement: Any person who knowingly and with intent to defraud any insurance company, or files an application for insurance or statement of claim containing any material, false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects the person to criminal and civil penalties.