Employee Incident Report

Employer Information

Date____/____/___

Employer's Name: _____

And Address: _____Contact:_____

Employers Phone #:_____/_____/_____ Employers Fax #_____/_____/_____

Policy #_____

Employee Information

Employee's Name_____

And Address: _____

Employee's phone #:_____-_____-_____Employee's Date of Hire:_____/_____/_____

Employee's occupation:_____Employee's weekly pay rate:__$_____

Employee's SSN_____-_____-_____ Date of Birth ___/___/___ Male/Female_____

Accident information

Date of loss_____ Time of day of accident:__:____Date lost time began___/___/___

Date returned to work ___/____/___ Date reported to employer____/_____/_____

Supervisor's Name:_____Address where accident occurred:_____

Witness:_____Have you ever been treated for a similar injury Y___N_____

Physician's Name & Address_____

Description of
Accident:_____

_____

_____

Nature of injury (Body Part):

I certify that the above information is true and correct to the best of my knowledge. I understand that if I am declining medical treatment at this time that my Employer will not be responsible for any expense related to the Incident or any resulting injury. I further understand that I will not be eligible for benefits under the plan unless I receive medical care from an approved provider within 14 days from the date of incident.

Employee's Signature: Date: