

WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION ()		CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
SUBSIDIARY NAME		SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)		SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME
DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED				
PARENT COMPANY / INSURED'S NAME				
LOCATION CODE	POLICY SYMBOL AND NUMBER		NATURE OF BUSINESS	
DATE OF INJURY			TIME OF INJURY	
ACCIDENT DESCRIPTION				

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS	
EMPLOYEE'S HOME PHONE NUMBER ()	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____	INJURED WORKER TYPE	REGULAR OCCUPATION
OCCUPATION WHEN INJURED		
EMPLOYEE'S WORK SCHEDULE		
REGULAR WORK HOURS	HOURS/DAY	DAYS/WEEK
EMPLOYEE'S WAGE INFORMATION: \$ _____ / HOUR OR \$ _____ / ANNUAL OR \$ _____ / WEEKLY OVERTIME: \$ _____ ADDITIONAL BENEFITS: \$ _____		
DATE OF HIRE OR LENGTH OF EMPLOYMENT		
SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER: ()	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK?
RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)		

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM?
 YES NO

WITNESS INFORMATION/OTHERS INVOLVED

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER
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CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

YES NO

TREATMENT ("X" ALL THAT APPLY)

FIRST AID —

TREATMENT AND DATE OF 1ST TREATMENT

HOSPITAL/
CLINIC —

NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED?

WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM?

YES NO

WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT?

YES NO

PHYSICIAN —

**SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS
FOR YOUR INDIVIDUAL STATE.**

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION
