NOTICE OF INJURY

Please call us immediately following a work related injury/illness with as much of the following information as possible.
Call 1-800-775-2404 or FAX to 1-866-214-9505

EMPLOYER INFORMATION

Date: ____________________

Employer Name: ____________________

Contact Person: ____________________

Contact Email: ____________________

Address/Location: ____________________

City: ____________________ State: __________ Zip Code: __________

Phone Number: ____________________ Fax Number: ____________________

INJURY INFORMATION

Employee Name: ____________________ Home/Cell Phone: ____________________

Employee Email: ____________________

Injury Date: ____________________ Date Employer Notified: ____________________

Time Shift Began: ______________ Time of Injury: ______________

Where did the injury occur? ____________________

What was the employee doing leading up to the injury: ____________________

How did the injury occur? ____________________

Body part(s) affected: ____________________

Type of injury: ____________________

Returned to work? ☐ **Yes** Date Returned: ______________ ☐ **No**

PHYSICIAN INFORMATION

Physician/Hospital: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Phone Number: ____________________

Treated in the Emergency Room? ☐ **Yes** ☐ **No** Hospitalized overnight? ☐ **Yes** ☐ **No**

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