IMPORTANT: Complete this form within 24 hours of any workplace injury. Retain a copy for your records.

SECTION 1: EMPLOYER INFORMATION

Company/Contractor Name:

Address:

City: State: ZIP Code:

Phone: Workers' Comp Policy #:

Insurance Carrier: Job Site Name/Address (if different):

SECTION 2: INJURED EMPLOYEE INFORMATION

Employee Name (Last, First, MI): Date of Birth:

Home Address:

City: State: ZIP Code:

Phone (Home): Phone (Cell):

Social Security # (Last 4 digits): Email:

Job Title/Occupation: Department: Hire Date:

Employment Status:

☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Seasonal ☐ Subcontractor

SECTION 3: INCIDENT DETAILS

Date of Injury:

Time of Injury:

Date Reported:

Location Where Injury Occurred (be specific):

What was the employee doing when injured?

How did the injury occur? (Describe in detail)

Type of Incident:

- ☐ Slip/Trip/Fall
- ☐ Struck By Object
- ☐ Caught In/Between
- ☐ Overexertion
- ☐ Vehicle Accident
- ☐ Repetitive Motion
- ☐ Exposure (Chemical/Heat/Cold)
- ☐ Other

SECTION 4: INJURY INFORMATION

Body Part(s) Injured:

☐ Head/Face ☐ Neck ☐ Shoulder ☐ Arm/Elbow ☐ Wrist/Hand ☐ Fingers

☐ Back (Upper) ☐ Back (Lower) ☐ Chest/Ribs ☐ Abdomen ☐ Hip/Pelvis

☐ Leg/Knee ☐ Ankle/Foot ☐ Toes ☐ Multiple ☐ Other:

Type of Injury:

☐ Cut/Laceration ☐ Bruise/Contusion ☐ Sprain/Strain ☐ Fracture

☐ Burn ☐ Puncture ☐ Amputation ☐ Crush Injury ☐ Other:

Describe the injury in detail:

SECTION 5: MEDICAL TREATMENT

Was medical treatment provided?

☐ Yes ☐ No ☐ Refused by Employee

Type of treatment:

☐ First Aid On-Site ☐ Urgent Care ☐ Emergency Room ☐ Doctor's Office ☐ Hospitalized

Name of Treating Physician/Facility:

Address: Phone:

Date of Treatment: Time Lost from Work:

Has employee returned to work?

☐ Yes - Full Duty ☐ Yes - Modified Duty ☐ No - Still Off Work

SECTION 6: WITNESS INFORMATION

Witness 1 Name: Phone:

Witness 2 Name: Phone:

SECTION 7: REPORT COMPLETED BY

Name: Title:

Phone: Email:

CERTIFICATION & SIGNATURES

I certify that the information provided in this report is true and accurate to the best of my knowledge.

Supervisor/Manager Signature Date

Employee Signature (if able) Date

NEXT STEPS:

Submit this form to your insurance carrier within 24-48 hours. Keep copies for your records and provide one to the injured employee.

CLAIMS REPORTING ASSISTANCE

First Underwriters Insurance Brokers: (425) 242-5357

Email: claims@firstunderwriters.com