You are responsible for answering all questions on the **E**mployee's **W**ork **I**njury **R**eport accurately and in detail. This will make the processing of your claim both accurate and timely. This completed report should be given to the workers' compensation contact within 24 hours of your work-related injury

Employee's Work Injury Report

Personal

Name _____ Social Security Number _____

Address _____ Birth Date _____ Sex M ☐ F ☐

City, State _____ Zip _____ Telephone _____

Married ☐ Single ☐ Number of Dependents _____ Home/School _____

Family Physician _____ Telephone Number _____

Are you currently entitled to Medicare Benefits? N ☐ Y ☐ Medicare #(HICN) _____

Have you applied for Medicare or SSDI? N ☐ Y ☐ Pending ☐ Rejected ☐

Employment

Job Title _____ Employment Date _____

Salary/Hourly Rate _____ Hours Worked Per Day _____

Building Location _____ Time Work Day Begins _____

Injury/Illness

Date of Injury _____ Time of Accident _____

Where in the facility/job site did this injury occur? _____

What were you doing when injured? _____

How did the injury occur? _____

Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.)

Any previous similar injury? If yes, explain. _____

Was this injury witnessed? If so, by whom? _____

Did you lose time from work? Yes ☐ No ☐ Date(s) missed _____

Have you returned? Yes ☐ No ☐ If yes, what was the date? _____

Treatment

Medical Facility _____

Diagnosis/Care Prescribed _____

Contact

When you return to work, you must call _____

Employee's Signature (PRINTED) _____ Date _____

Employee's Signature _____

RI0051

CLEAR FORM

EMC INSURANCE