

EMPLOYEE'S REPORT OF INCIDENT AND INJURY

PLEASE PRINT IN INK

To be completed by Employee

Employer:

Name _____ Social Sec. No. _____
Home Address _____ Birth Date _____ Sex: Male Female
City/State/Zip _____ Telephone: () _____

Date of injury **or** onset of symptoms _____ Time _____ am pm
Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:** _____

Did anyone see you get hurt? Yes No If yes, who? _____
Did you report this incident to anyone? Yes No If not, why not? _____
If yes, to whom did you report it? _____ Title/Position _____ When? _____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull) _____

Was any first aid provided at the scene? Yes No If yes, describe: _____
Did you seek other medical treatment? Yes No If yes, when? _____
Where? _____ If treatment was not sought immediately, explain why: _____

Is this an aggravation of a previous injury/symptom? Yes No If yes, when were you last treated for the previous injury?
By whom or where? _____
Have you ever had a similar injury? Yes No If yes, describe other injury: _____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc., a Sedgwick CMS company**. A copy of this form will serve as the original.

Employee Name (print) _____

Employee Signature _____

Date (required) _____

SUPERVISOR'S INVESTIGATION REPORT

Employer: _____
Employee Name: _____ **Soc. Sec. #** _____
Date of Injury: _____

Was an investigation completed concerning the circumstances of this injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were there any witnesses to this injury? If yes, witness statements should be attached.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has there been any recent disciplinary action taken against this employee? If yes, please describe (and attach any written documentation): _____ _____		
Has the employee missed any work previously due to similar industrial or non -industrial conditions? If so, when? _____ What preventive action measures do you recommend? _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the employee submitted medical documentation for the injury? If so, please attach.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If known, please provide us with the name, address and telephone number of the attending physician: _____ _____ _____		
Has the employee returned to work? _____ Last day worked _____ Returned to work _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If not, what is the current estimated date of return? _____		
With the information you have, would you recommend the claim be accepted? If no, why? _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ Employer's signature	_____ Title	_____ Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.