

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	CALLER'S EMAIL ADDRESS	EMPLOYMENT 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	DOES THE EMPLOYEE SPEAK ENGLISH? <input type="checkbox"/> (Yes) <input type="checkbox"/> (No)
EMPLOYEE'S HOME PHONE NUMBER ()	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS
EMPLOYEE'S CELL PHONE NUMBER ()		

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____	REGULAR ASSIGNED DEPARTMENT	REGULAR OCCUPATION
DEPARTMENT WHEN INJURED	OCCUPATION WHEN INJURED	
EMPLOYEE'S WORK SCHEDULE REGULAR WORK HOURS: HOURS/DAY _____ DAYS/WEEK _____		
EMPLOYEE'S WAGE INFORMATION: \$ _____ / HOUR OR \$ _____ / ANNUAL OR \$ _____ / WEEKLY	DOES THE EMPLOYEE WORK A VARIED SCHEDULE <input type="checkbox"/> (Yes) <input type="checkbox"/> (No)	
DATE OF HIRE:	IF DATE OF HIRE IS UNKNOWN, WHAT IS LENGTH OF EMPLOYMENT? YEARS _____ MONTHS _____	
SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER: ()	BEST HOURS TO CONTACT
	SUPERVISOR'S EMAIL ADDRESS:	

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER:	WAS INJURY FATAL? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE OF DEATH (MM/DD/YYYY) ___/___/_____	DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID EMPLOYEE GET PAID FOR DAY OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE EMPLOYEE LAST WORKED:	IS EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
IS EMPLOYEE WORKING HIS REGULAR NUMBER OF HOURS <input type="checkbox"/> YES <input type="checkbox"/> NO		IS EMPLOYEE ON LIGHT/ MODIFIED DUTY? <input type="checkbox"/> YES <input type="checkbox"/> NO
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)		
ARE YOU AWARE OF ANY ISSUES THAT WOULD MAKE YOU QUESTION THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, ARE YOU QUESTIONING WHETHER THIS INJURY IS WORK-RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO

WITNESS INFORMATION/OTHERS INVOLVED NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

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

DATE OF 1ST TREATMENT: _____

TREATMENT: _____

HOSPITAL/
CLINIC

FACILITY NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

PHYSICIAN NAME: _____

TREATMENT: _____

DATE OF 1ST TREATMENT: _____

LENGTH OF STAY: _____

AMBULANCE USED? YES NO

WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? YES NO

WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? YES NO

PHYSICIAN

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

TREATMENT DESCRIPTION: _____

WHO IS THE PRIMARY CONTACT FOR THIS CLAIM?

NAME and TITLE:

PHONE NUMBER: ()

EMAIL:

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

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION
