



WORKER'S COMPENSATION INJURY / ILLNESS REPORT - HR

This form shall be completed by the Employer / Supervisor / HR Representative as soon as possible.

Claim Type: [] Injury [] Illness [] Near Miss [] Death Today's Date Time [] AM [] PM

EMPLOYER & WCOMP INFO. Employer Name, Employer EIN, Employer Location, Employer Tel. No., Employer Address, Street, City, State & Zip, Nature of Business, Worker's Compensation Insurance Carrier Name, Policy No., WComp Telephone No., WComp Fax No., Worker's Compensation Insurance Address, Street, City, State & Zip, Self-Insured? [] Yes [] No

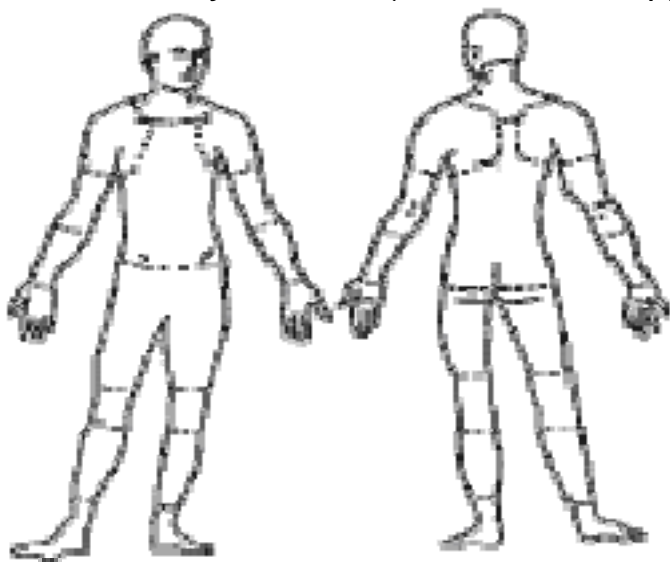
EMPLOYEE INFORMATION Employee Name, Employee Social Security No., Date of Birth, Date of Hire, Employee Address, Street, City, State & Zip, Employee Tel. No., Gender [] Male [] Female, Marital Status [] Single [] Married, Employment Status [] Full-Time [] Part-Time [] Seasonal, Job Title, Occupation Description, NCCI Class Code, Department Regularly Worked, Wage \$, [] per Hour [] per Year, Pay Cycle [] Weekly (52x) [] Semi-Monthly (24x) [] Bi-Weekly (26x) [] Monthly (12x), No. of Hours Worked Per Week, Salary Continued in Lieu of Compensation? [] Yes [] No, Full Wages Paid for Date of Injury? [] Yes [] No

ACCIDENT / INJURY Date of Injury: (mm/dd/yyyy) Time of Injury: [] AM [] PM Date Employer Notified of Injury: Date Last Day Worked: Date Disability Began: Time Employee Began Work on Injury Date: [] AM [] PM Return to Work Date (if applicable) Date of Death (if applicable) If Death Claim, Give # of Dependents for Each Relationship: [] Widow [] Mother Child(ren) [] Total [] Widower [] Father Other [] Total [] Did Injury/Illness Occur on Employer's Premises? [] Yes [] No Describe in detail what let up to the injury / illness (use additional sheet if necessary) Give names of witnesses (if any): What was the employee doing prior to the event? What equipment / tools being used? What protective device was being used at the time of accident? (if any) Why did the incident happen? (Unsafe workplace condition. Check all that apply) [] Unguarded hazard [] Safety device / tools defective [] Unsafe lighting [] Unsafe Ventilation [] Lack of appropriate equipment / tools [] Unsafe clothing [] No or lack of training [] Other: (Unsafe acts by people. Check all that apply) [] Operating without permission [] Operating at unsafe speed [] Taking an unsafe position / posture [] Using defective equipment [] Failure to wear protective device [] Distraction, teasing, horseplay [] Unsafe lifting [] Other:

PREVENTION What changes do you suggest to prevent this incident from happening again? [] Stop this activity [] Enforce existing policy [] Train the employee(s) [] Routinely inspect for the hazard [] Redesign work station [] Redesign task steps [] Train the supervisor(s) [] Other [] Write a new policy / rule [] Guard the hazard [] Update Protective Equipment



TREATMENT	FIRST-TIME EMERGENCIES CAN GO TO ANY HOSPITAL OR QUICKCARE			
	Physician Name		Name of Hospital or Off-Site Treatment Facility	
	Street Address		Street Address	
	City State & Zip	Tel. No. ()	City State & Zip	Tel. No. ()
Initial Treatment		<input type="checkbox"/> Minor Treated By Employer <input type="checkbox"/> Minor Treated By Clinic/Hospital <input type="checkbox"/> Hospitalized >24 Hrs		
<input type="checkbox"/> No Medical Treatment		<input type="checkbox"/> Emergency Care <input type="checkbox"/> Future Major Medical / Lost Time Anticipated		

DESCRIPTION OF INJURY	Part of the body affected: (Shade all that apply)		Nature of injury: (Most Serious)	
			<input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn → <input type="checkbox"/> Heat <input type="checkbox"/> Chemical <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to the body system Other: _____ _____	

SIGNATURE	Preparer's Name	Job Title	Date
	Witness's Name	Job Title	Date
	Name of Employer	Telephone No,	

In Case of A Work-Related Injury / Illness Go To

Any UMC Quick Care Centers

Any Fremont Medical Centers

First Time Emergencies Can Go To Any Hospitals or Quickcares

PLEASE FAX COMPLETED FORM TO ADVANSTAFF HR at (702) 598-0646