



Please call us immediately following a work related injury/illness
with as much of the following information as possible.
Call 1-800-775-2404 or FAX to 1-866-214-9505

NOTICE OF INJURY

EMPLOYER INFORMATION

Date: ____ / ____ / ____

Employer Name: _____

Contact Person: _____

Address/Location: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ - _____

INJURY INFORMATION

Employee Name: _____ Home/Cell Phone: (____) _____ - _____

Injury Date: ____ / ____ / ____ Date Employer Notified: ____ / ____ / ____

Time Shift Began: _____ Time of Injury: _____

Where did the injury occur: _____

What was the employee doing leading up to the injury: _____

How did the injury occur: _____

Body part(s) affected: _____

Type of injury: _____

Returned to work: Yes ____ Date Returned: ____ / ____ / ____ No ____

PHYSICIAN INFORMATION

Physician/Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ - _____

Treated in the Emergency Room: Yes ____ No ____ Hospitalized overnight: Yes ____ No ____