

EMPLOYEE'S INJURY REPORT



Claim No. _____

To enable the Company to give your case prompt attention in accordance with the compensation law, please complete this form in full and return it immediately in the enclosed envelope which requires no postage stamp.

NAME OF EMPLOYER		HOW LONG HAVE YOU WORKED FOR THIS EMPLOYER?	
ARE YOU LIVING IN YOUR EMPLOYER'S HOUSEHOLD OR PREMISES?		IF RELATED TO EMPLOYER, STATE RELATIONSHIP	
OCCUPATION WHEN INJURED		WERE YOU DOING YOUR REGULAR WORK?	
ON WHOSE PAY ROLL WHEN INJURED?		WAGES WHEN INJURED (Per day, per week)	WORK DAYS PER WEEK
WERE YOU A TEMPORARY OR STEADY EMPLOYEE?		AGE	ARE YOU MARRIED?
NO. OF CHILDREN AND AGE OF EACH			
IF UNDER 21 YEARS, GIVE NAME AND ADDRESS OF YOUR PARENT OR GUARDIAN			
DATE OF INJURY (Hour)		DATE YOU WERE FORCED TO LEAVE WORK BECAUSE OF YOUR INJURY (Hour)	
PLACE WHERE INJURY WAS SUSTAINED (No., Street, City or Town)		WERE YOU ON EMPLOYER'S PREMISES?	
WAS INJURY CAUSED BY ANOTHER PERSON?		NAME OF OTHER PERSON	
WHO IS HE EMPLOYED BY?			
HAVE YOU CLAIMED OR RECEIVED SETTLEMENT FOR THIS INJURY?			FROM WHOM?
NAME AND ADDRESS OF TWO EYE WITNESSES			
WHEN DID YOU FIRST REPORT YOUR INJURY?		TO WHOM DID YOU FIRST REPORT YOUR INJURY?	
NAME OF YOUR DOCTOR		DOCTOR'S ADDRESS	
HAVE YOU RETURNED TO WORK?		IF SO, WHAT DATE?	
DESCRIBE YOUR INJURY AND HOW ACCIDENT HAPPENED			
DATE OF THIS REPORT		SIGNATURE	
ADDRESS (No., Street, City or Town)		TELEPHONE NUMBER	