SENTINEL

CLAIM REPORTING: WORKERS' COMPENSATION

INSTRUCTIONS: The injured employee(s) shall use this form to report all work-related injuries, illnesses, or "near miss" events (which could have caused an injury or illness). This helps in identifying and correcting hazards within the workplace as well as provides pertinent information in the event of an incident. This form shall be completed by employees as soon as possible and given to a supervisor for further action. ***IMPORTANT – Please complete ALL the fields below to the best of your ability.***

I am reporting a work related: Injury Illness Near-Miss

Injured Employee Name: ______________________________ Policy #: ____________________

Date of Birth: _________________________ Social Security #: ___________________________

Phone: ______________________________ Email: ______________________________________

Home Street Address: ____

City: ____________________________________ State: ________________ Zip: ___________

Employer/Company Name: ______________________ Supervisor: _______________________

Date Hired: _____________________________ Last Day Worked: ______________________

Date of Incident: _________________________ Time of Incident: _______________________

Date Incident Reported to Employer: _________________________

To Whom Was It Reported: ____

First Day Back to Work After Incident: _____________ Working: Light Duty Full Duty

Name of Witnesses (if any): ____

Address Where Incident Occurred:

Street Address: ____

City: ________________________________ State: ___________________ Zip: _____________

Describe step by step what led up to the incident:

What could have been done to prevent this incident?

What parts if your body were injured? If a near miss, how could you have been hurt?

Was any body part injured before? Yes No

If yes, what and when: ____

Please list the name, address, phone, and date/time of visit of all medical providers the injured worker treated with for this incident:

Employee Signature: ____ Date: _______________

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