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:

Signature: _____ Date: _____