ACCIDENT – WORKERS' COMPENSATION REPORT

Name: ______________________ Date ______________________

SSN: ______________________ DOB: ______________________

Date of Injury: ______________ Time of Injury: ______________

Location When Injured: ______________________

Employer: ______________________

Employer's Address ______________________

Employer's Phone #: ______________ Supervisor's Name: ______________

Was your supervisor notified of the accident? ☐ YES ☐ NO When: ______________

State in your own words where and how the accident occurred: ______________________

____

If the accident involved a motor vehicle, state where you were seated in the vehicle: ______________

____

Have you been treated by anyone else for this injury? ______________________

If so, by whom? ______________________

Where any x-rays taken or laboratory procedures performed? ☐ YES ☐ NO

Where? ______________________

When? ______________________

Findings/Diagnosis: ______________________

Are you still under that provider's care? ☐ YES ☐ NO

Did you have any pain immediately following the accident or injury? ☐ YES ☐ NO

Describe the pain's nature and location

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Where is your current pain? ______________________

____

Is it: ☐ Worsening ☐ Improving ☐ Unchanged

What is the last day you worked? ______________________

Is there anything else you want us to know? ______________________

(Please do not write below this line)

Insurance Carrier: ______________________

Telephone Number: ______________________

Adjuster's Name: ______________________

Claim Number: ______________________

Confirmed on (date): ______________ By (Employer's Agent's name): ______________

NCCC Employee's Initials: ______________________