

EMPLOYER OCCUPATIONAL INJURY OR DISEASE REPORT

Policy Number: _____
Claim or File Number: _____

Employer's Name: _____
Employer's Address: _____
Employer's Telephone Number: _____
Employer's Business: _____

Employee's Name: _____
Employee's Address: _____
Employee's Marital Status: _____ Spouse's Name: _____
Employee's Date of Birth: _____
Employee's Occupation: _____
Employee's Length of Employment: _____

Date of Injury or Illness: _____
Where Did Injury or Illness Occur: _____
Was Employee Medically Evaluated: _____ By Who and When: _____
What Was Prognosis: _____

Physician's Name: _____
Physician's Address: _____
Physician's Phone Number: _____

What Equipment Was Used During Occurrence: _____
Describe Employee's Activity Prior to Occurrence: _____

Describe How Injury or Illness Occurred: _____

What Happened After the Occurrence: _____

Employee's Rate of Pay: _____ Per (year, week, hour): _____
Average Number of Hours Worked Per Week: _____
Did Employee Receive Full Pay for Occurrence Date: _____
Did Salary Continue After the Occurrence: _____

Witness Name: _____
Witness Address: _____
Witness Phone Number: _____
Witness Occupation: _____

Date of Report: _____

Signature

Official Title