

EMPLOYEE REPORT OF WORK-RELATED INJURY

EMPLOYEE INFO

Employee Name: _____
Mailing Address: _____
Street Address: _____
City, State, Zip Code: _____
Date of Birth: _____ Social Security #: _____
Marital Status: _____ # Dependents: _____ Home Phone: _____
Job Title: _____ Department: _____ Supervisor: _____
Normal Work Hours Begin: _____ End: _____ Work Location: _____
Do You Also Work For Another Employer? Yes No If Yes, Name and Address: _____

INJURY / ACCIDENT

Date of Accident: _____ Time: _____ Where Did Injury Happen? _____
Date Reported to Employer: _____ Who Did You Report It To?: _____
Description of Accident: _____

Witnesses: 1) _____ 2) _____
What Object, Substance or Exposure Contributed to Your Injury? _____

MEDICAL

Physician's Name and Address: _____

Description of Current Complaint(s): _____

Are You Still Being Treated For This Injury? Yes No
Did You Lose Time From Work? Yes No If Yes, Date of Incapacity: _____

PRIOR INJURIES

Please Describe Prior Injuries: _____

Are You Still Treating For Prior Injuries? Yes No If Yes, With Whom? _____
Was Prior Injury Covered By Workers' Compensation? Yes No
If Yes, Employer: _____ Insurance Carrier: _____



Please Indicate Location of Injury on Diagram on Opposite Page (Over)



ACKNOWLEDGEMENT

Today's Date: _____ Signature: _____

M M T A W C T

P.O. Box 5198, Augusta, ME 04332-5198
Phone (207)623-1807 Fax (207)622-6804

NOTICE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. 24-A M.R.S.A. Section 2186 (3)(A)

INDICATE LOCATION OF INJURY ON DIAGRAM

