

# Employee's Report of Injury

**Step 1: Please complete and submit no matter how minor the injury.**

<b>Last Name:</b>	<b>First Name:</b>	<b>M.I.</b>	<b>SSN:</b>
<b>Street Address:</b>			<b>Apt.</b>
<b>City:</b>		<b>State:</b>	<b>Zip:</b>
<b>Phone Number:</b>	<b>Email Address:</b>		<b>Date of Birth:</b>
<b>Employer:</b>	<b>Job Title:</b>	<b>Department:</b>	
<b>Injury Reported To:</b>	<b>Position:</b>	<b>Date Reported:</b>	
<b>Date of Injury:</b>	<b>Last Day Worked:</b>	<b>Return to Work Date:</b>	

**Where did the injury occur?**

**What were you doing when the injury occurred?**

**How did the injury occur?**

**What object or substance caused the injury?**

**Type of Injury:** \_\_\_\_\_ **Part of Body:** \_\_\_\_\_

**What type of treatment was received?**

**Who witnessed the accident?**

**Was the injury caused by someone else?**  No  Yes

Name:

**Did the accident involve employees or equipment from another company?**  No  Yes

**What actions (if any) were taken to prevent similar accidents from occurring?**

**Have you had a Workers' Comp claim in the last year?**  No  Yes

If Yes, When:

**Have you had a previous injury to this body part?**  No  Yes

If Yes, When:

<b>Department:</b>	<b>Job title at time of incident:</b>
Are you currently going to physical therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work schedule: <input type="checkbox"/> Regular Full-Time <input type="checkbox"/> Regular Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
Are you taking pain medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Months with this employer:
Are you taking any other medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Months doing this job:

If yes, please list all medications:

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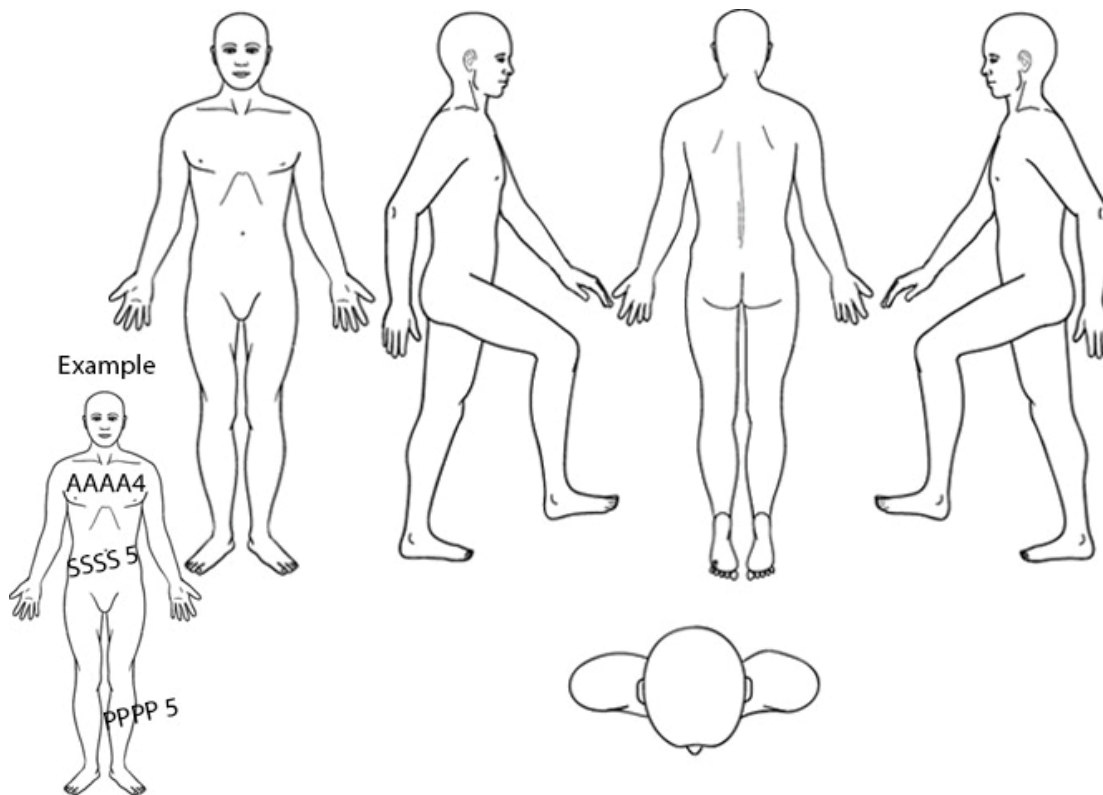
## Step 2: Pain chart.

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

<b>Description:</b>	Numbness	Pins & Needles	Burning	Aching	Stabbing
<b>Symbol</b>	NNNN	PPPP	BBBB	AAAA	SSSS

### Nature of injury: (most serious one)

<input type="checkbox"/> Abrasion, scrapes	<input type="checkbox"/> Amputation	<input type="checkbox"/> Broken bone	<input type="checkbox"/> Bruise
<input type="checkbox"/> Burn (heat)	<input type="checkbox"/> Burn (chemical)	<input type="checkbox"/> Concussion (to the head)	<input type="checkbox"/> Crushing Injury
<input type="checkbox"/> Cut, laceration, puncture	<input type="checkbox"/> Hernia	<input type="checkbox"/> Illness	<input type="checkbox"/> Sprain, strain
<input type="checkbox"/> Damage to a body system: (e.g. nervous, respiratory, or circulatory system):			
<input type="checkbox"/> Other:			



*Note: Any person who knowingly provides false, incomplete, or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.*

Employee Name (print) \_\_\_\_\_

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please fax completed form to (480) 289-6220 or email to [WCNewClaims@NationalPEO.com](mailto:WCNewClaims@NationalPEO.com)**