

# WORKSHEET FOR WORKERS' COMPENSATION TELEPHONE REPORTING

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

**DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.**

## ACCOUNT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION ( )	CALLER'S NAME (FIRST, MI, LAST)	CALLER'S TITLE	BENEFIT STATE
EMPLOYER'S NAME	EMPLOYER'S ADDRESS (STREET, CITY, STATE & ZIP)	EMPLOYER'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME	
PARENT COMPANY / INSURED'S NAME	LOCATION CODE	NATURE OF BUSINESS	POLICY FORM
POLICY NUMBER			

## EMPLOYEE INFORMATION

EMPLOYEE'S NAME (FIRST, MI, LAST)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER			
EMPLOYEE'S MAILING ADDRESS (STREET, CITY, STATE & ZIP)		IS EMPLOYEE'S HOME ADDRESS THE SAME? IF NO, STREET, CITY, STATE & ZIP <input type="checkbox"/> YES <input type="checkbox"/> NO				
MARITAL STATUS	EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NO. OF DEPENDENTS	CLASS CODE	DATE OF BIRTH	WAGE PERIOD	HOME PHONE NUMBER ( )

## ACCIDENT INFORMATION

DATE OF INJURY	TIME OF INJURY A.M.    P.M.	DATE CLAIM REPORTED TO EMPLOYER	WAS THE ACCIDENT ON THE EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LOCATION OF ACCIDENT ADDRESS (STREET, CITY, STATE & ZIP)			COUNTY			
DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? IF YES, DATE RETURNED <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE EMPLOYEE LAST WORKED	WAS EMPLOYEE PAID FOR DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DATE EMPLOYEE LAST PAID	DATE DISABILITY BEGAN	DATE DISABILITY ENDED	IS / WAS EMPLOYEE'S SALARY CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
WAS EMPLOYEE'S INJURY RELATED TO A COMPANY-SPONSORED EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			WAS ACCIDENT FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO			

FULL DESCRIPTION OF ACCIDENT

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CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)	IF MOTOR VEHICLE ACCIDENT, DRIVER'S LICENSE NUMBER	STATE WHERE ISSUED
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CONTRIBUTING FACTORS	EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED
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IF OTHER PARTIES WERE INVOLVED NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER
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WERE SAFEGUARDS PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DESCRIPTION OF SAFEGUARDS	WERE SAFEGUARDS IN USE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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WITNESS INFORMATION NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER
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## INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)	NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)	PREVIOUS RELATED CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRE-EXISTING MEDICAL CONDITION(S)
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CUMULATIVE INJURY? IF YES, LENGTH OF EXPOSURE <input type="checkbox"/> YES <input type="checkbox"/> NO	NATURE OF DUTIES	LENGTH OF TIME DOING ACTIVITY
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TREATMENT ("X" ALL THAT APPLY)			
<input type="checkbox"/> FIRST AID—	NAME (FIRST, MI, LAST)	WHAT TYPE OF FIRST AID WAS ADMINISTERED?	1ST DAY OF TREATMENT
<input type="checkbox"/> HOSPITAL/ CLINIC —	NAME AND ADDRESS (STREET, CITY, STATE & ZIP)	TREATMENT	LENGTH OF STAY
<input type="checkbox"/> PHYSICIAN —	NAME AND ADDRESS (STREET, CITY, STATE & ZIP)	PHONE NUMBER ( )	SPECIALTY
		TREATMENT	1ST DAY OF TREATMENT



