Workers' Compensation Claim Form

INCIDENT REPORT

OSHA Log #: ______

Days Restricted: ______

Days Lost: ______

Completed By: ______

Title: ______

Phone #: ______

Date: ______

Time Workday Began: ______ ☐ AM ☐ PM

1. Location Reporting Claim: ______

Time of Accident: ______ ☐ AM ☐ PM

2. Employee Name: ______

3. Date of Accident: ______

4. Soc. Sec. No.: ______

5. Complete Address of Accident
Including: City, State & Zip Code

6. Birthdate: ______

7. Martial Status: ______ 8. Sex: ☐ M ☐ F

9. Employee Home Address:
Including: City, State & Zip Code

10. Home Phone: ______

11. Date of Hire: ______

12. Number of Dependant Children: ______

13. Regular Occupation: ______

14. Employees State of Hire: ______

15. Occupation When Injured: ______

16. Length at Current Occupation: ______

17. Hours Per Day: ______

18. Department: ______

19. What Was The Employee Doing Just Before The Incident?

20. How Did It Happen?

21. Body Part: ______

22. Object That Directly Injured Employee: ______

23. Date Employee Began Losing Time: ______

24. Employee's scheduled work week: ☐ Sun ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa

25. Date Employee Return To Work: ______

26. Was Employee Paid For A Full Day: ☐ Yes ☐ No

27. Any Foreseeable Loss Time or Perm Disability: ______

28. Name and Address of Hospital:

29. Name and Address of Doctor:

30. Emergency Room Visit: ☐ Yes ☐ No

31. Hospitalized Overnight: ☐ Yes ☐ No

32. Date of Follow Up Visits: ______

33. Contact Person: ______

34. Witnesses: ______

35. Any Reason to Doubt the Claim: ☐ Yes ☐ No

36. Date Reported to Employer: ______

37. Reported To Whom: ______

OSHA Reportable Accidents (fatalities, hospital admissions, amputations or loss of an eye) must be reported to OSHA by calling (800)321-6742.

* Fatalities must be reported within 8 hours.
* Accidents resulting in hospital admissions, amputations or loss of an eye must be reported within 24 hours.