WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

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 DE	LAY IN	CALLING IF	YOU	DO NOT H	IAVE ANSV	VERS TO	ALL THE	QUESTIONS	S.		
			ACCOUN	NT / A			ATION					
CALLER'S PHONE NUMBER / EXTENS	ION CALLER	CALLER'S TITLE			ER'S NAME					REPORTING STATE		
() SUBSIDIARY NAME	SUBSIDI	SUBSIDIARY'S ADDRESS (STREET, CITY			STATE & ZIP) SUBSIDIARY'S MAILING ADDRESS (ADDRESS (STI	 TREET, CITY, STATE & ZIP)			
DID THE ACCIDENT OCCUR AT THE L												
YES NO IF NO, ADDRES	SS WHERE ACCID	ENT OCC	URRED									
PARENT COMPANY / INSURED'S NAM	E											
LOCATION CODE	POLICY SYMBOL AND NUMBER				NATURE OF BUSINES			S				
DATE OF INJURY						TIME OF IN	JURY					
ACCIDENT DESCRIPTION												
EMPLOYEE INFORMATION												
INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:			EMPLOYEE'S	NAME	FIRST, MI, LAST)					GENDER		
										MALE	FEMALE	
DATE OF BIRTH		EMF	PLOYEE'S MAILII	NG ADE	DRESS							
EMPLOYEE'S HOME PHONE NUMBER	EMF	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)										
EMPLOYEE JOB INFORMATION												
EMPLOYMENT STATUS CODE INJ					INJURED WOF	RKER TYPE			REGULAR OCC	UPATION		
OCCUPATION WHEN INJURED		·										
EMPLOYEE'S WORK SCHEDULE												
REGULAR WORK HOURS HOURS/DAY DAYS/WEEK												
EMPLOYEE'S WAGE INFORMATION: \$/HOUR OR \$/ANNUAL OR \$/WEEKLY					OVERTIME: \$ ADDITIONAL BENEFITS				BENEFITS: \$	<u>.</u>		
DATE OF HIRE OR LENGTH OF EMPLO	OYMENT											
SUPERVISOR'S NAME:					SUPERVISOR'S PHONE NUMBER: BEST					HOURS TO CONTACT		
					()							
						RMATIO						
DATE CLAIM REPORTED TO EMPLOYER? DID EMPLOYEE LOSE ANY TIME FROM V					/ORK? IS THE EMPLOYEE BACK AT WORK?					WORKS		
RETURN TO WORK STATUS										F YES, DATE OF DEATH		
										LO, DATE OF DEA		
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)					CONTRIBUTING FACTORS							
EQUIPMENT, MATERIAL OR SUBSTAN	ICE INVOLVED											
IF OTHER PEOPLE WERE INVOLVED NAME (FIRST, MI, LAST) ADDRESS				PHONE NUMBER								
DO YOU QUESTION THE VALIDITY OF	THE CLAIM?											
WITNESS INFORMATION NAME (FIRST, MI, LAST) ADDRESS				PHONE NUMBER								

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

	E-EXISTING CONDITION(S) (IF YES, DESCIBE)
TREATMENT ("X" ALL T	HAT APPLY
FIRST AID —	TREATMENT AND DATE OF 1 ST TREATMENT
	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1 ST TREATMENT, LENGTH OF STAY, AMBULANCE USED?

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION