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| **Workers Comp Injury/Illness**  **Tracking Number:** |
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| |  |  |  |  | | --- | --- | --- | --- | | **Employee Information** | | | | | Employee :\* |  | | | | Employee Home State or Prov : |  |  |  | | Country or work location : |  | Department : |  | | Executive : |  | Manager Phone : |  | | Manager Name: |  | Marital Status : |  | | Number Of Dependant Under Age 18:\* |  |  |  | |
| |  |  |  |  | | --- | --- | --- | --- | | **Injury/Illness Information** | | | | | Date of Injury (DD-MM-YYYY) :\* |  | Time Of Injury\* | (HH24:MM) | | Hours Worked Date Of Injury :\* | (HH24:MM) | | | | Normal Working Hours From :\* | (HH24:MM) | Normal Working Hours To :\* | (HH24:MM) | | Date Employer knew of Injury (DD-MM-YYYY) |  |  |  | | Injury Reported to Name : |  | Title : |  | | Did Incident Result in loss of workdays? : |  | If so possible length of disability : | Days | | If lost work days,first full day out (DD-MM-YYYY) |  | | | | Has injured returned to work : |  | If so,date returned |  | |  |  | Time : | (HH24:MM) | |
| |  | | --- | | **Additional Information** | | Address of accident or illness(please note if this is off-site) : |  | | | | Address/Phone number of local DecisionOne office : |  | | | | Describe how injury or illness occurred and state what employee was doing at the time : |  | | | | Part of body affected ( Eg.left leg,right hand,etc.) : |  | | | | Name,Address and Phone of Physician/hospital (please complete in full) : |  | | | | Type of treatment received (Example : X-rays (positive or negative),therapy,prescription,etc) : |  | | | |  |  |  |  | | Do you have any reason to doubt this claim?If yes, please explain: : |  | | | |