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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:\* |       |  |  |

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| **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) |

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| **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) : |       |
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| Do you have any reason to doubt this claim?If yes, please explain: : |       |

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