

ICRMT
WC Employee Injury Report
(to be completed by injured employee)

Your Name: _____ Home Phone: _____

Hire Date: _____ SSN: _____ Date of Birth: _____

Home Address & Phone: _____

Marital Status: Single Married Divorced # Dependents: _____

Date/Time of Incident: _____ Time Shift Began: _____ Date/Time Reported: _____

Address of accident occurrence: _____

Body part and how it was affected: _____

What were you doing when the accident occurred? _____

Reason for being in the area: _____

How did the accident occur ? (use 2nd sheet if necessary): _____

Who else saw the incident? _____

To whom did you report the incident? _____

Have you received first aid? Yes No Were you treated in the Emergency Room? Yes No
If yes, check One: On Premise Were you hospitalized overnight as an inpatient? Yes No
 Outside medical assistance Has your doctor taken you off of work? Yes No
 Both

When is your next medical appointment? _____

Name, address, phone and fax # (if available) of medical facility where treatment was sought: _____

Date/Time of such treatment: _____

Prior Workers' Compensation Claims? Yes No

If yes, please explain using 2nd sheet if necessary (i.e. date, body part, injury specifics): _____

I agree the above is true and accurate

Employee's Signature: _____ Date: _____