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

Insured: _____

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
If yes, check One: ☐ On Premise
☐ Outside medical assistance
☐ Both

Were you treated in the Emergency Room? ☐ Yes ☐ No
Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No
Has your doctor taken you off of work? ☐ Yes ☐ No

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 (i.e. date, body part, injury specifics):_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I agree the above is true and accurate

Employee's Signature: _____ Date: _____