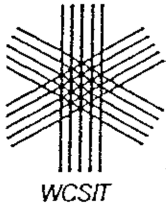

REPORT ALL ACCIDENTS IMMEDIATELY TO:
HINZ CLAIM MANAGEMENT, INC.

INJURED WORKER'S REPORT OF INJURY

(PLEASE PRINT OR TYPE)

ENDORS

EMPLOYER INFORMATION

A

Employer______________________ Phone (____)__________

Address______________________

Supervisor______________________

INJURED WORKER NFORMATION

B

Name______________________

Address______________________

Phone # (____)______________ Social Security #______________

Dependent(s) Names & Ages______________________

Occupation______________________

Date of Hire______________ Other Employment______________

INJURY

C

Date______________ Time______________ Place______________

Witness(es)______________ Address______________

Witness(es)______________ Address______________

Nature of Injury & Body Part(s) Injured______________________

Last Day Worked______________ Return to Work Date or Expected Return to Work Date______________

Treating Doctor or Clinic______________________

How Did Accident Happen?______________________

____

____

____

____

e______________________19______ ______________________
Signature of Employee

3850 (REV 95)

Injury report for Worker's Compensation

Full Name: ____

Address: ____

____

Telephone Number: ____________________ Date of Birth: ____________________

Height: __________ Weight: __________ Marital Status: ____________

Dependents (Names & Ages): ____

____

Employer: ____________________ Location: ____________________

Job Title: ____________________

Date of Hire: ____________________ Supervisor: ____________________

Description of job duties: ____

____

Weekly gross pay: $____________ Hourly __________ Salary __________

Work Hours: ____________________ Days Worked: ____________________

Any other form of employment? (Full or Part Time) ____________________

If yes, please provide is with the name of employer and job duties____________________

____

Date of Injury: ____________________ Time: ____________________

Describe what happened and where the injury occurred: ____________________

____

____

____

____

____

Did anyone witness the accident? Yes ________ No ________

If you answered yes to the above question, please list their names ________________

____

Who did you report the injury to? ______________________________________

When did you report the injury? Date ________________ Time ____________

What are your symptoms and injuries? (list all body parts involved) ______________

____

When and where did you get your first treatment? ___________________________

List names and addresses of all doctors you have seen? _______________________

____

Who referred you to the doctors you have seen? ____________________________

Please list the name(s) and addresses(es) of all of your past and present family doctors:

____

____

Have you missed any work because of the injury? ______ Dates: ______________

Have you ever been injured at work before? __________ If yes, list injuries, dates and names of employers: ____

____

Have you ever injured the body parts involved in this incident before? ______ If yes, when and where ____

What type of treatment have you received for this injury? _____________________

____

Do you have any hobbies or participate in any sports? _______________________

Are you currently receiving any disability payments or pensions? ________ If yes, list details of payments: ____

Are all facts stated above true and correct to the best of your knowledge? ___________

Signature: ________________________________ Date: ________________

Social Security Number: ______________________