InSource Employer Solutions

_____
(Name of InSource's Client Employing Injured Worker)

EMPLOYER'S REPORT OF INCIDENT

COMPLETE ALL BLANKS

Date of This Report: _____ **Date of Incident:** _____

Name of Injured Worker: _____ **SS#:** _____

Birthdate: _____/_____/_____ **Date Employee Reported Incident:** _____

Home Address: _____ **Phone #:** _____

City, State, ZIP: _____ **Hire Date:** _____

Does the injured worker have: Health Insurance? _____ **Pre-Existing Conditions?** _____

Injured Worker's Occupation: _____ **Pay Rate:** _____

Is Injured Worker Part-Time of Full-Time? _____ **Full pay on day of injury?** _____

Days Injured Worker Typically Works: _____

Time of Incident: _____ **Time Employee Reported for Work Day of Incident:** _____

Person Employee Reported Incident To: _____

Client Where Incident Occurred: _____

Address Where Incident Occurred: _____

Was the Injured Worker administered a drug test immediately following the incident? _____

If yes, what were the results? _____ **(Please send a copy of results)**

Has employee lost time from work? **(If yes, give dates of lost time and if employee has returned to work)**
_____

Describe the incident in detail (how, why, where, what):
_____
_____

Is a third party (another company or individual) responsible for this incident? If yes, please give details:
_____

Type of Injury (cut, sprain, bruise, fracture, etc.): _____

Which part of body injured (be specific): _____

Are there any safety issues that contributed to this injury? If so, please detail:
_____

List all witnesses to this incident, including names and phone numbers:
_____

Name of Medical Facility Where Employee Taken: _____

Phone Number: _____ **Address of Facility:** _____

Do you have any particular concerns with this claim?
_____

Name of Employer Contact Completing This Report: _____
(Print Name & Phone Number)

Employer Contact's Signature: _____

****REPORT DUE WITHIN 24 HOURS OF ACCIDENT****
**** Also complete the Employee's Report of Incident****

Supplemental Questionnaire

Injured Worker's Occupation:_____

Detailed Description of Injured Worker's Job Duties:_____

_____

Injured Workers Marital Status:_____

Sex of Injured Worker:_____

Was a Post-Offer Medical Questionnaire completed at the time of hire?_____

Was the injured worker administered an alcohol test after the incident?_____

*If Yes, what were the results?_____

How would you describe this employee's work history?_____

Have there been similar incidents involving this employee?_____

*If yes, please provide details:_____

_____

Have there been any disciplinary actions against this employee?_____

*If yes, please provide details:_____

_____