

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: _____

Date of Initial Medical Treatment: _____

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:** _____
