InSource Employer Solutions

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(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?

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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:**____

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Did this employee report their claim to the employer more than one day after the date of the incident? If so, why?

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If reporting this incident to InSource more than two days after the employee reported this incident to the employer, be prepared to provide additional details for a reason for the delay.