Workers Compensation First Report of Accident

Company Name:

Policy Number ________________________ Claim Number ____________________

Employee Name: ____________________________ Date: ________________

Address: ____

SSN: __________________ Gender: ______ Full Time or Part Time

Marital Status: ________________________ Date of Birth___________

Home Phone Number: ________________ Pay Rate: _________________

Occupation / Job Title: ________________ Date of Hire________________

Date of Injury: _______________Time of Injury: ___________ A.M. or P.M

Full Pay for Date of Injury No ____ Yes _____

Describe work employee was performing at time of accident:

____
____
____
____
____
____

Describe where and how accident occurred:

____
____
____
____
____
____
____

Were there any witnesses who actually saw the accident? No ___ Yes ___
Who? ____

Witnesses phone #____________________

Part of body injured: _____________________________

Was injury related to a previous injury? ___________________

Medical Treatment:
( ) First aid on premises
( ) Professional medical treatment
( ) Hospitalization

Employee Work Released For:
( ) Regular duty on ________________
( ) Restricted duty _________________
( ) Off-work, re-check on ____________

Treatment given by: ____

Address: ____

Was immediate corrective action taken? No _____ Yes _____
If yes, what? ____
____

Did you ever notify your immediate supervisor about the problem? No____ Yes _____.If yes, when? _______________ More than once No______ Yes______

Did you ever notify your HR department? No____ Yes____ If yes, when? _____

Additional action taken / comments: ___________________________________
____

Report By: ______________________ Reviewed By: _____________________
Site Safety Supervisor

Date: ______________________ Date: ____________________

Please fax completed form to Claims 619-461-2456 or you may email to Claims@bhiservices.com. If you have any questions please call 619-461-6022.

BLUE HORIZON INSURANCE SERVICES