

# Report of Injury

Employer: \_\_\_\_\_ Risk #: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Employee's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employee's Phone #: \_\_\_\_\_

Employee's SSN: - - Date of Birth: / / Gender: M F

Date of Injury: / /

Injury Description: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Body Part(s) Injured: \_\_\_\_\_

Treating Provider's Name: \_\_\_\_\_

Treating Provider's Address: \_\_\_\_\_

\_\_\_\_\_  
Treating Provider's Phone #: \_\_\_\_\_

Last Date Worked: / / Return to Work Date: / /

Follow-up Date to see Physician: / /

Certify or Reject Claim:  **Certify**  **Reject**

Reason to Reject: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Completed By Title Date