Email Form

# WORKERS COMPENSATION TELEPHONE REPORTING WORKSHEET

Call the Network (1-877-863-5095) to report all Workers Compensation injuries. The following information is requested to report a claim.

## ACCOUNT / ACCIDENT INFORMATION

| CALLER'S PHONE NUMBER / EXTENSION ( ) | CALLER'S TITLE | CALLER'S NAME | CALLER'S EMAIL ADDRESS | EMPLOYMENT STATE |
|---|---|---|---|---|
| INSURED'S NAME | INSURED'S ADDRESS (STREET, CITY, STATE & ZIP) | INSURED'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) ☐ SAME | | |
| DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? ☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED | | | | |
| LOCATION CODE | POLICY NUMBER | POLICY EFFECTIVE DATES | NATURE OF BUSINESS | |
| DATE OF INJURY | TIME OF INJURY | ACCIDENT DESCRIPTION | | |

## EMPLOYEE INFORMATION

| INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER | EMPLOYEE'S NAME (FIRST, MI, LAST) | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|
| DATE OF BIRTH | EMPLOYEE'S MAILING ADDRESS | DOES THE EMPLOYEE SPEAK ENGLISH? ☐ YES ☐ NO |
| EMPLOYEE'S PHONE NUMBER HOME ( ) CELL ( ) | EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING) | EMPLOYEE'S EMAIL ADDRESS |

## EMPLOYEE JOB INFORMATION

| EMPLOYMENT STATUS CODE ☐ FULL-TIME ☐ PART-TIME OTHER _____ | REGULAR ASSIGNED DEPARTMENT | REGULAR OCCUPATION |
|---|---|---|
| DEPARTMENT WHEN INJURED | OCCUPATION WHEN INJURED | |
| EMPLOYEE'S WORK SCHEDULE REGULAR WORK HOURS HOURS/DAY _____ DAYS/WEEK _____ | | |
| EMPLOYEE'S WAGE INFORMATION $ _____ / HOUR OR $ _____ / ANNUAL OR $ _____ / WEEKLY | DOES THE EMPLOYEE WORK A VARIED SCHEDULE ☐ YES ☐ NO | |
| DATE OF HIRE | IF DATE OF HIRE IS UNKNOWN, WHAT IS LENGTH OF EMPLOYMENT? YEARS _____ MONTHS _____ | |
| SUPERVISOR'S NAME | SUPERVISOR'S PHONE NUMBER ( ) | SUPERVISOR'S EMAIL ADDRESS / BEST HOURS TO CONTACT |

## ACCIDENT INFORMATION

| DATE CLAIM REPORTED TO EMPLOYER | WAS INJURY FATAL? ☐ YES ☐ NO | IF YES, DATE OF DEATH (MM/DD/YYYY) ___/___/___ | DID EMPLOYEE LOSE ANY TIME FROM WORK? ☐ YES ☐ NO |
|---|---|---|---|
| DID EMPLOYEE GET PAID FOR DAY OF INJURY? ☐ YES ☐ NO | DATE EMPLOYEE LAST WORKED | IS EMPLOYEE BACK AT WORK? ☐ YES ☐ NO | IF YES, DATE EMPLOYEE RETURNED TO WORK |
| IS EMPLOYEE WORKING HIS REGULAR NUMBER OF HOURS ☐ YES ☐ NO | | IS EMPLOYEE ON LIGHT / MODIFIED DUTY? ☐ YES ☐ NO | |
| CAUSE OF ACCIDENT (E.G., SLIP / FALL, LIFTING, CHEMICAL) | | | |
| ARE YOU AWARE OF ANY ISSUES THAT WOULD MAKE YOU QUESTION THIS INJURY? ☐ YES ☐ NO | | IF YES, ARE YOU QUESTIONING WHETHER THIS INJURY IS WORK-RELATED? ☐ YES ☐ NO | |
| WITNESS INFORMATION / OTHERS INVOLVED NAME (FIRST, MI, LAST) | ADDRESS | PHONE NUMBER | |
| | | | |
| | | | |

## INJURY INFORMATION

| PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG) | | | |
|---|---|---|---|
| NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION) | | | |
| PRIOR INJURY OR PRE-EXTISTING CONDITION(S) (IF YES, DESCRIBE) ☐ YES ☐ NO | | | |
| HOSPITAL / CLINIC | DAY OF 1ST TREATMENT | LENGTH OF STAY | AMBULANCE USED? ☐ YES ☐ NO |
| | WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO | WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO | |
| PHYSICIAN | NAME | | |
| | ADDRESS | PHONE NUMBER | |
| | TREATMENT DESCRIPTION | | |
| | | | |
| WHO IS THE PRIMARY CONTACT FOR THIS CLAIM? NAME AND TITLE | | | |
| PHONE NUMBER | EMAIL | | |