Employee's Report of Injury

Please complete and submit no matter how minor the injury.

Last Name: ______________ First Name: ______________ M.I. ____ SSN: ______________

Street Address: ______________ Apt. ____ City: ______________ State: ________ Zip: ________

Phone Number: ______________ Email Address: ______________ Date of Birth: ______________

Employer: ______________ Job Title: ______________ Department: ______________

Injury reported to: ______________ Position: ______________ Date reported: ______________

Date of injury: ______________ Last day worked: ______________ Return to work date: ______________

Where did the injury occur? ______________

What were you doing when the injury occured? ______________

____

How did the injury occur? ______________

____

What object or substance caused the injury? ______________

Type of injury: ______________ Part of body: ______________

What type of treatment was received? ______________

Who witnessed the accident? ______________

Was the injury caused by someone else? ☐ No ☐ Yes Name: ______________

Did the accident involve employees or equipment from another company? ☐ No ☐ Yes

What actions (if any) were taken to prevent similar accidents from occurring? ______________

____

Have you had a Workers' Comp claim in the last year? ☐ No ☐ Yes If Yes, when: ______________

Have you had a previous injury to this body part? ☐ No ☐ Yes If Yes, when: ______________

Note: Any person who knowingly provides false, incomplete or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines and denial of insurance benefits.

Employee Name (print): ______________

Employee Signature: ______________ Date: ______________

Please fax completed form to (888) 252 -5217 or email to risk@keyhro.com