IMPORTANT
To be completed by Employer

Employer's Report of Injury

Complete and fax or email this reprot within 24 hours from the time of accident.

6959 University Blvd, Winter Park FL 32792 | Toll Free (800) 922-4133 | Fax (888) 252-5217 | www.keyhro.com

The clients designated supervisor must notify Key HR (on this form) of every injury or disease suffered by an employee, arising out of and in the course of employment.

Please fill out this form by clicking on the fields and typing the appropriate information on each line.

Employee

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

Street Address:_____ Apt: _____ City:_____ State:_____ Zip: _____

Phone Number:_____ Date of Birth:_____ Department: _____

History of Claims

Does Employee have any previous Work Comp Claims? ☐ No ☐ Yes If "Yes", please provide details below such as date of claim and type of injury. _____

Employer

Current Employer: Key HR LLC Company Name: _____ Date of Hire: _____

Company Information

Office Address: _____ Suite:_____ City:_____ St:_____ Zip: _____

Phone:_____ Fax:_____ Nature of Business: _____

Accident

Date of Injury:_____ Hour of Injury:_____ AM ☐ PM ☐ Date Employer Notified: _____

Last Day Worked:_____ Date Returned to Work:_____ Class Code: _____

Employees Occupation (Job Title) When Injured:_____ Department: _____

Can a light duty position be accomodated? ☐ No ☐ Yes

Nature of Injury:_____ Part of body injured:_____ On Company Premises? ☐ No ☐ Yes

Was claimaint working at your company's client location? ☐ No ☐ Yes

Name/Address/Location of Accident: _____

Was the employee paid for the day of injury? ☐ No ☐ Yes Time employee began work:_____ ☐ AM ☐ PM

Hospital or Clinic Name:_____ Phone:_____ City:_____ St:_____ Zip: _____

If validity of Claim is Doubted, State Reason: _____

Cause of Accident

How Did Accident Happen? _____

Specify Machine, Tool, Substance, or Object most closely connected with Accident: _____

What was Employee doing when Accident occurred? _____

If another person not in Company Employ caused the Accident, give name and Address:_____

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

Supervisor's Report of Injury

Please complete and submit within 24 hours no matter how minor the injury.

Company: _____

Injured Employee: _____

Date of Injury: _____ Time of Injury: _____AM ☐ PM ☐

Injury reported to: _____ Date reported: _____

Was the employee paid for a full days work? ☐ No ☐ Yes

Did the employee lose at least one full day of work after the injury? No ☐ ☐ Yes

Date last worked: _____ Time: _____AM ☐ PM ☐

Has the employee returned to work? ☐ No ☐ Yes Date: _____

Was the employee performing assigned duties? ☐ No ☐ Yes

Location where the injury occured: _____

What was the employee doing when injured? _____

How did the injury occur? _____

Object or substance that injured the employee? _____

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 any other company? No ☐ Yes ☐

What (if any) safety procedures were violated? _____

Is the employee an officer partner or relative of the employer? ☐ No ☐ Yes

Please include any additional comments you feel are important on the other side.

Supervisor Name (print): _____ Date: _____

Supervisor Signature: _____

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

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: _____

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