

Workers Compensation Employee Report of Injury

Section One: Personal Information

Employee Name/Title: _____ Social Security Number: _____

Date of Birth: _____ Marital Status: _____ Sex: Male Female

Employee Address: _____
Street City State Zip

Home Phone: _____ Emergency Contact: _____
Name/Phone

Section Two: Injury Information

Date injury occurred: _____ Time of Injury: _____ Shift injury occurred on: _____

Program: _____ Witness to: _____

Description of Injury:(print clearly)

Describe the specific job responsibility the employee was performing at the time of injury:

Supervisor's Information:

Physician/Clinic: _____ Address: _____ Phone: _____

Last Day Worked: _____ Date Returned/Expected to Return Work: _____

I hereby authorize all hospitals, clinics, medical centers, therapists, and all others who have examined, attended professionally or who have been consulted concerning me at this time to release and furnish to Allied Human Services, Inc. all information and records concerning me. This authorization includes furnishing and delivery to Allied Human Services, Inc. of reproduced/photocopies of notes, reports, and records. This authorization shall remain valid until such time that my care has been completed.



Employee Signature Date Supervisor Signature Date

FAX COMPLETED FORM TO HUMAN RESOURCES AT 248-641-0407