Employee Application for Compensation and Report of Injury or Occupational Disease

All questions below must be answered or there may be a delay in payment of benefits.

EMPLOYEES NAME: FIRST MIDDLE LAST

MAILING ADDRESS CITY, STATE, ZIP CODE

TELEPHONE S	JOB TITLE	SOCIAL SECURITY #	D.O.B.	MARITAL STATUS

GENDER	HEIGHT	WEIGHT	NATURE OF INJURY	DATE & TIME OCCURRED A.MJ P.M.

DESCRIBE ACCIDENT FULLY, WHAT YOU WERE DOING AT TIME OF INJURY, WHAT CAUSED THE INJURY. IN DETAIL MENTION ANY CONTRIBUTING FACTORS; IF MACHINERY INVOLVED OR NAME CHEMICAL INVOLVED IF APPROPRIATE.

NAME OF ALL WITNESSES	DATE LAST WORKED	RETURN TO WORK DATE
	NOW LONG HAVE YOU WORKED FOR T143 EMPLOYER	WERE YOU **Doing** YOUR REGULAR JOB AT TIME OF IN*JURY?*
INJURY WAS REPORTED TO EMPLOYER ON:	WAS ACCIDENT CAUSED BY *ANYONE* EMPLOYED BY YOUR EMPLOYER?	*WAS* ***ACCIDENT*** CAUSED BY FAILURE OF MACHINE OR PRODUCT?

WHOM WAS NOTIFIED (NAME & TITLE)	IF REPORTING OF ACCIDENT WAS DELAYED, WHY?
DID YOU LOSE ANY TIME FROM WORK BEYOND DAY OF INJURY?	HAVE YOU EVER BEEN TREATED FOR SIMILAR INJURY? (DESCRIBE)

RATE OF **PAY** AT TIME OF INJURY $ HOUR DAY WEEK MONTH (CIRCLE ONE)

HOW MANY DAYS! HOURS PER WEEK ARE EMPLOYED?	SHIFT SCHEDULE	WERE YOU TRANSFERRED TO ANOTHER JOB?

NAME & ADDRESS OF ATTENDING PHYSICIAN	NAME OF HOSPITAL

MEDICAL RELEASE AUTHORIZATION I HEREBY AUTHORIZE MY PHYSICIAN, HOSPITAL AGENCY TO DISCLOSE TO MY EMPLOYER ANY MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH AHS PREVIUSLY BEEN FURNISHED TO ME.	EMPLOYEE SIGNATURE

I DECLARE THAT THE FOREGOING STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

ALL ORIGINALS MUST BE SUBMITTED TO THE WORKERS COMPENSATION PROGRAM

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