EMPLOYEE ACCIDENT / INJURY REPORT

COMPANY NAME____________________________________

To process your Workers' Compensation Claim promptly, employee must sign and return this form to APP

Name____________________________________ Social Security #:____________________

Address____

City: ________________________________ State: ________________ Zip Code____________

Date of Birth________________ Phone#:______________________ Hire Date:________________ __

Client Name (if applicable)____________________________ Department: ______________

Address where injury occurred:____

Date of Injury__________ Time of Injury __________*(a/p)* Time work day began:________(a/p)

Job Title: ____ Status: ( ) Part Time) Full Time

Fully describe how the accident occurred, listing specific body part injured (left, right, upper, lower, etc.)

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Did or do you require medical treatment?____

Where did you or where will you receive medical treatment?__________________________________

Name of supervisor & phone number:____

Have you returned to work? Yes No If "Yes", give date. ______________________________

Name of witness(es): ____

When did you report accident to your supervisor______________________________________

Have you had any previous injuries of this nature?_____Yes_____No

If "Yes", provide full details (Date, Employer, Doctor, Etc.)

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Authorization to Release Information: I hereby authorize any physician, hospital or other person or Institution to permit the Insurance Company or its representative to examine, make or be furnished with any information concerning illness or injury sustained by me. This includes treatment, consultations, medical history, hospital records, prescriptions, diagnosis or findings. A photo static copy of this authorization shall be considered as valid as the original.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Employee Signature______________________________________ Date____________________

Employer Representative__________________________________ Date____________________