STRATUS.HR
Elevated HR for elite employers

Workers' Comp. Accident Report Form

Please print clearly and complete all items on this page:

Part 1 :: Client / Employee Information

Client / Company Name: ______________________ **Co. Phone Number:** ______________

Employee Full Name: (First Middle Last) ______________________ ☐ **Male** ☐ **Female**

Employee ID*: ☐☐☐☐☐☐☐☐☐☐☐☐☐ **AND/OR** **Last 4 digits of Social Security:** ☐☐☐☐

Birth Date: ____________ Hire Date: ____________ **Phone Number:** ____________

Current Address: ______________________

City: ______________________ State: ________ Zip: ________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Dependents: ________

Shift Start: ________ am/pm to Shift End ________ am/pm Days Normally Worked: ☐ Su ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa

Job Title: ______________ Wage Rate: ______________ Hand Dominance: ☐ Right ☐ Left

Part 2 :: Accident / Incident Information (to be filled out by employee or supervisor)

Date of Incident: ____________ Time of Incident: ____________ Time Started Work: ____________

Date of Report: ____________ Name of Supervisor: ______________________

Department were you regularly work: ______________ On regular job at the time of Incident? ☐ Yes ☐ No

Did incident occur on company premises? ☐ Yes ☐ No If no provide address: ______________

Please describe the activity/work process the employee was engaged in at the time of the incident. Please note machinery, tools, and equipment used: ______________________

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Type of injury (laceration, fracture, etc): ______________ Part of body: ______________

Names and phone numbers of any witness(s): ______________________

Was medical treatment sought? ☐ Yes ☐ No

Medical Facility Address & Phone number: ______________________

Date Last Worked: ______________ Date Returned to Work: ______________

Has employee injured this body part before? If so, provide details: ______________________

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Please describe your hobbies: ______________________

I, the undersigned, hereby permit the release and disclosure of any and all medical information records, reports and documents relative the issues necessary for the administration of a claim to my employer and their designated representative. I further agree that a photocopy will act as the equivalent of the original. My signature certifies that the information contained in this report is completely truthful and I understand that falsification of information may subject me to corrective disciplinary action up to an including termination.

______________________ ______________
Signature of Employee **Date** (MM/DD/YEAR)

______________________ ______________
Signature of Supervisor **Date** (MM/DD/YEAR)

FOR INTERNAL USE ONLY: Do not write below this line							
Carrier:		Policy Number:		W/C Code:		Date Submitted to Carrier:	

* Enter your Employee ID, if known. Your Employee ID can be found on your paystub, in Tech Center or on the Mobile App. The number of digits in your Employee ID may be less than the space available above.