# A picture containing clipart  Description automatically generated

# Employer Report of Accident Form

## Employee Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | SSN: |   |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |
| --- | --- | --- |
| Date of Birth:  |  |  |
| Hire Date:  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Position: |  |  |  |

|  |  |  |
| --- | --- | --- |
| Risk Class:  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Injury: |  | Time of Injury: |   | Start Time (Date of Injury): |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Has employee missed time from work?  | YES[ ]  | NO[ ]  |  |  |  |
| **Last Date Worked:** **Date Returned to Work:**Is temporary light duty work available during recovery? | YES[ ]  | NO[ ]  |
| Is the employee an Owner, Partner, Volunteer, Corporate Shareholder/Director/Officer -OR- Does the employee have optional L&I coverage elected?  | YES[ ]  | NO[ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| Were you contributing to this employee’s and/or family’s health care benefits (medical, dental and/or vision insurance) on the date of injury? | YES[ ]  | NO[ ]  |  |

|  |  |
| --- | --- |
| **If yes, please provide the date coverage ends:**Employer’s *Monthly* Contribution to Benefits: | $ |

## Business Information

|  |  |  |  |
| --- | --- | --- | --- |
| Business: |  | Mailing Address: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| UBI: |  | L&I Account: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Injury Location: |  | Address of Injury Location: |  |

|  |  |  |
| --- | --- | --- |
| Does this business have a maritime function? | YES[ ]  | NO[ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| Business Telephone: |  | ( |  |

## Wage Information

|  |  |  |  |
| --- | --- | --- | --- |
| Rate of Pay: |  |  |  |
| Frequency of Pay (Hourly, Daily, Weekly, Monthly, Other): |  |  |  |
| Average Daily Earnings from Other Sources (Piecework, Tips, Commissions, Other): |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hours/Day:  |  | Days/Week: |  | Average Overtime/Pay Period: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you pay wages/salary if employee is off work? | YES[ ]  | NO[ ]  |  |

|  |  |
| --- | --- |
| Type of Pay (Regular Wages/Salary, Paid Time Off, Vacation, Sick, Contractual, Other): |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Did the employee receive any bonuses 12 months prior to the date of injury?**Amount/Type of Bonus:**  | YES[ ]  | NO[ ]  |  |

## Accident/Occupational Disease Information

|  |  |
| --- | --- |
| Describe how the accident occurred: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Body part(s) injured or exposed, including side of body: |  |  |  |
| Employer comments or concerns:  |  |

|  |  |  |
| --- | --- | --- |
| Is the employee deceased? | YES[ ]  | NO[ ]  |

|  |  |  |
| --- | --- | --- |
| Do you question the validity of this claim? | YES[ ]  | NO[ ]  |

|  |  |  |
| --- | --- | --- |
| Was this injury caused by a faulty machine or product or someone who is not your employee? | YES[ ]  | NO[ ]  |
| Did the employee report this accident or occupational disease exposure? | YES[ ]  | NO[ ]  |

**Date Reported:**

|  |  |  |
| --- | --- | --- |
| Did the employee seek medical treatment? | YES[ ]  | NO[ ]  |

|  |  |  |
| --- | --- | --- |
| If yes, did the employee provide you with a copy of his/her activity prescription form? *Please attach the copy.* | YES[ ]  | NO[ ]  |

|  |  |  |
| --- | --- | --- |
| Is the employee released to his/her job of injury or modified duty? | YES[ ]  | NO[ ]  |

|  |  |  |
| --- | --- | --- |
| If the employee is released to his/her job of injury or modified duty, was a copy of the signed certified job analysis returned to you? *Please attach the copy.* | YES[ ]  | NO[ ]  |

## Witness Information

Please provide the name(s) and contact information of all witness(es) to this accident or occupational exposure:

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Position: |  |
| Company: |  | Phone: |  |
| Address: |  |  |  |
|  |  |  |  |
| Full Name: |  | Position: |  |
| Company: |  | Phone: |  |
| Address: |  |  |  |
|  |  |  |  |
| Full Name: |  | Position: |  |
| Company: |  | Phone: |  |
| Address: |  |  |  |

## Signature

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Employer Representative Completing Form: |   | Telephone: |    |

I declare to these statements to be true to the best of my knowledge and belief.

 Signature:

|  |  |  |
| --- | --- | --- |
| Date: |  |  |

\_\_\_\_\_\_(ATTACH & INITIAL) I certify at least 13 weeks of the employee’s payroll records (immediately preceding the above listed date of injury) are attached. If the employee has been with your business for less than 13 weeks, payroll records from their date of hire to present are attached.