Report of Injury Packet

Please complete the following forms within one day of the injury. All 3 of the following forms ***must*** be filled out, signed and dated. If there are no witnesses, please state "no witness" as the witness name. Thank you.

Phone: 480.429.8098 Fax: 480.945.1525 www.nationalpeo.com

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Worker's Report of Injury

Please complete this form after any injury occurs and return to your supervisor within one day of your injury and include any medical documentation

Company Name: ________________________________ Date: ______________

Employee Name: ________________________________ Social Security #: ______________

Job Title: ________________________________ Supervisor Name: ______________

Address: ____

City: ______________ State: ____________ Zip: ______________

Phone: ______________ Marital Status: ____________ Birth Date: ______________

Date of Injury: ______________________ Time Of Injury: _______ AM PM

Location of Injury? (address): ____

Time you began working: ________________ Date and time supervisor notified: ____________

Were you on O/T when injured? Yes No Were you paid for date of injury? Yes No

Please describe in detail how the injury occurred:

What was the injury? (sprain, strain, laceration, fracture, etc.) ______________________________

Part of body injured: ____________________ Body side injured: Right Left

Was treatment provided for the injury? Please give name and address of doctors and hospitals:

Are you expected to miss any days of work? Yes No If yes, how many? __________

Do you have work restrictions? If so, what? ____

Did anyone (or anything) cause or contribute to the injury? If so, please list:

Signature: ____ Date: ____________

Completed By (please print): ______________________________ Title: ____________

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Supervisor's Report of Injury

Please complete this form after any injury occurs and return to your Work Comp Department at National PEO. All injuries should be reported immediately.

Client Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Business Type: ______________________________

Days/week company operates: 5 6 7

Employee Name: ______________________________

Address: ______________________________

____

Phone: ________________ DOB: ________________

Marital Status: __________ SS#: ________________

Job Title: ______________________________

Date of Injury: ______________________________

Time Of Injury: __________ AM PM

Employee Hire Date: __________________________

Employee's Regular Hours: __________ to __________

Time employee began working: ________________

Has the employee returned to work? Yes No

Employee on O/T when injured? Yes No

Employee paid for date of injury? Yes No

Please describe in detail how the injury occurred:

What was the injury? (sprain, strain, laceration, fracture, etc.) ______________________________

Part of body injured: __________________________ Body side injured: Right Left

Was treatment provided for the injury? Please give name and address of doctors and hospitals:

Is employee expected to miss any days of work? Yes No If yes, how many? ____________

If employee has work restrictions, is a modified duty position available? Yes No

If the accident was caused by someone else, please list their name and address:

If validity of injury is doubted, state reason here:

Supervisor Signature: ______________________________ Date: ______________

Supervisor Print Name: ______________________________ Title: ______________

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Witness Statement

Please complete this form after any injury occurs and return to your supervisor within one day of the injury

Company Name: ____ Date: ______________________

Witness Name: ________________________________ Injured Employee Name: ________________________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Address: ____

City: __________________________ State: _________________ Zip: ____________________

Relationship to Injured Worker: ____

Date of Injury: ________________________________ Time Of Injury: __________ AM PM

Where did the injury happen? (location in building or worksite) ____

Name(s) of other employees involved: ____

Name(s) of other witnesses: ____

The following is my statement of what I saw:

The following is my statement of what I heard the employee say:

I hereby certify that the above statements are a true and correct account of what I observed and /or heard.

Signature: ____ Date: ________________

Print Name: ____ Title: ________________

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