Sunwest Employer Services Inc.

WORKERS' COMPENSATION INJURY REPORTING GUIDE

Please complete where highlighted in yellow.

CLIENT/WORKSITE INFORMATION

CLIENT NAME, ADDRESS & PHONE #	NAME OF PERSON REPORTING THE INJURY/ACCIDENT
	NAME OF PERSON @ CLIENT SITE TO CONTACT FOR INFORMATION
	CONTACT PERSON'S PHONE NUMBER & EMAIL ADDRESS

INJURED EMPLOYEE INFORMATION & WAGE DETAILS

EMPLOYEE NAME(LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH	SOCIAL SECURITY NUMBER
		DATE OF HIRE	OCCUPATION / JOB TITLE
EMPLOYEE HOME ADDRESS (INCLUDE ZIP CODE)		RATE OF PAY ___ HOURLY $_____ ___ SALARY $ _____	# DAYS WORKED / PER WEEK _____ PAID FOR FULL DAY OF INJURY ___ YES ___ NO
PHONE # HOME CELL	SEX ___ MALE ___ FEMALE	EMPLOYMENT STATUS __ FULL TIME __ PART TIME	MARITAL STATUS ___ SINGLE ____ MARRIED ____ UNKNOWN # OF DEPENDENTS _____

ACCIDENT & TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY OR ILLNESS	TIME OF INJURY OR ILLNESS	DATE EMPLOYER NOTIFIED
DID INJURY / ILLNESS OCCUR ON EMPLOYER'S PREMISES? ___ YES ___ NO		TYPE OF INJURY / ILLNESS	
LOCATION WHERE INJURY OR ILLNESS OCCURRED IF NOT AT WORK SITE		PART OF BODY AFFECTED (Be specific - example: right hand or left hand)	
SPECIFIC ACTIVITY EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OCCURRED.		EQUIPMENT/MATERIAL EMPLOYEE WAS USING WHEN ACCIDENT HAPPENED	
		WORK EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OCCURRED	

HOW DID ACCIDENT OR ILLNESS OCCUR? BRIEFLY DESCRIBE THE SEQUENCE OF EVENTS & INCLUDE ANY OBJECT OR SUBSTANCES THAT WERE DIRECTLY INVOLVED IN THE ACCIDENT OR ILLNESS.

DATE RETURNED TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? _____ YES _____ NO WERE THEY USED? _____ YES _____ NO

HOSPITAL OR TREATMENT CARE FACILITY (FACILITY NAME, ADDRESS AND PHONE NUMBER)	INITIAL TREATMENT ___ NO MEDICAL TREATMENT GIVEN ___ FIRST AID GIVEN ___ URGENT CARE CLINIC/HOSPITAL ___ HOSPITAL EMERGENCY ROOM ___ HOSPITALIZED > 24 HOURS
WITNESS (NAME & PHONE NUMBER)	

DATE CARRIER NOTIFIED	PREPARER'S NAME & TITLE	PREPARER'S PHONE NUMBER

Work-related fatalities must be reported within 8 hours. All inpatient hospitalization, all amputations and all losses of an eye must be reported within 24 hours.