INCIDENT REPORT

ONLY USE THIS FORM IF ACCESS TO THE ONLINE INCIDENT REPORT IS NOT AVAILABLE.

EMPLOYEE: COMPLETE WITH YOUR SUPERVISOR.

SUPERVISOR: ENSURE ALL FIELDS ARE COMPLETED & SUBMIT WITH ALL OTHER PAPERWORK TO SHEAKLEY HR SOLUTIONS.

INJURED WORKER INFORMATION

LAST NAME, FIRST NAME, MIDDLE INITIAL		SOCIAL SECURITY NUMBER	MARITAL STATUS	DATE OF BIRTH
HOME MAILING ADDRESS			SEX (CIRCLE ONE) M F	NUMBER OF DEPENDENTS
CITY	STATE	ZIP CODE	COUNTY	DEPARTMENT NAME
OCCUPATION OR JOB TITLE		WORK DAYS (CIRCLE ALL THAT APPLY) SU M TU W TH F SA		REGULAR WORK HOURS FROM: TO:
TELPHONE NUMBER ( ) -		WORK NUMBER ( ) -		

INJURY/DISEASE/DEATH INFORMATION

DATE OF INJURY/DLEASE	TIME OF INJURY	DATE OF DEATH (IF FATAL)	DATE LAST WORKED	DATE RETURNED TO WORK
ACCIDENT LOCATION (STREET ADDRESS)		DATE HIRED	STATE WHERE HIRED	DATE EMPLOYER NOTIFIED
CITY	STATE	WAS PLACE OF ACCIDENT OR EXPOSURE ON EMPLOYER'S PREMISIS?		
DESCRIPTION OF ACCIDENT			TYPE OF INJURTY/DISEASE AND PART(S) OF BODY AFFECTED:	

TREATMENT INFORMATION

PHYSICIAN/HEALTH CARE PROVIDER NAME	TELEPHONE NUMBER ( ) -	FAX NUMBER ( ) -	INITIAL TREATMENT DATE
STREET ADDRESS	CITY	STATE	ZIP CODE
DIAGNOSIS(ES), INCLUDE ICD-9 CODE(S)		WILL THIS INCIDENT CAUSE THE INJURED WORKER TO MISS EIGHT (8) OR MORE DAYS OF WORK? (CIRCLE ONE) YES NO	
		IS THIS INJURY CAUSALLY RELEATED OT THE INDUSTRY INCIDENT? (CIRCLE ONE) YES NO	
PROVIDER SIGNATURE		BWC PROVIDER NUMBER	DATE

EMPLOYMENT INFORMATION

EMPLOYER NAME		EMPLOYER IS SELF-INSURING INJURED WORKER IS OWNER/PARTNER/MEMBER (CIRCLE ONE) YES NO		POLICY NUMBER
MAILING ADDRESS (STREET ADDRESS)				
CITY	STATE	ZIP CODE	COUNTY	TELEPHONE NUMBER ( ) -
EMPLOYER ACTION			REASONS/CONDITIONS	
EMPLOYER SIGNATURE			TITLE	DATE

WITNESS INFORMATION

NAME	STATEMENT DATE
STATEMENT	

Sheakley
IT'S DONE.