EMPLOYEE INCIDENT REPORT
(To be completed by Employee)

Full Name:_____ SS#:_____ DOB: _____

Date of incident or injury:_____Date of notice of incident or injury:_____

How and to whom did you report the incident or injury? _____

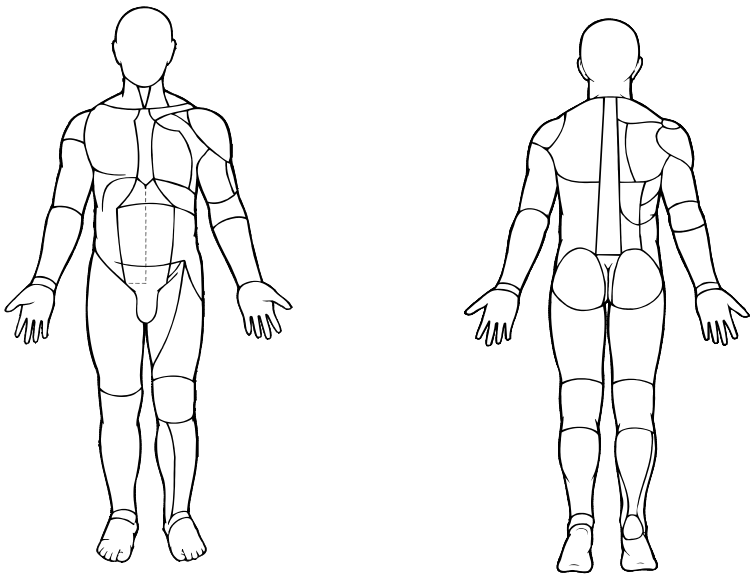
We will provide medical care for your compensable on the job injury. Do you feel you are in need of medical care or attention?___If you do not wish to receive care at this time please initial the following the following: ____.

Have you seen a physician or Health Care Provider for this injury?_____ Please state name and addresses of all physicians or health care providers you intend to see:
_____
_____

Family Doctor (if none, then Name & Address of Physician last seen other than for this incident):
_____

Describe (in Detail) the incident and circumstances which lead to the incident including how the injury occurred, body part(s) affected and onset date:
_____
_____
_____
_____
_____

Indicate on the chart(s) below the areas of body affected:



Provide name(s) of witnesses of the incident:

_____
_____
_____
_____
_____

Have you, in the past, seen, treated, or been evaluated by any Medical Doctor, Chiropractor, or any other health care provider for difficulties involving any of the body parts affected in this injury? _____

If so, please state the name and location of the provider, body part(s) for which you were seen and the circumstances which lead to your being seen:

_____
_____
_____
_____

Physician or Health Care Provider(s) seen in the past two years:

_____
_____
_____
_____
_____

During your employment, have you been employed elsewhere?_____ If so, please provide details:

_____
_____
_____
_____
_____

Comments:

_____
_____
_____
_____

Signed this _____ Day of _____, 20__

_____
Employee

_____
Supervisor

B&A

Supervisor Comments regarding validity of incident:

_____
_____
_____
_____
_____

Signed this _____ Day of _____, 20__

_____
Supervisor