CCMSI **EMPLOYEE'S REPORT OF INJURY**

Name _____ Claim # _____

Address _____

Occupation _____ Date of Birth _____ Soc. Sec. # _____

Sex _____ Married or Single _____ Employer _____

Employer's Address _____

Department _____ No. days/per week _____ Normal days off _____

Length of employment _____ Wages (hourly rate of pay) _____ Number hours worked/day _____

COMPLETE THE FOLLOWING IF YOU HAVE DEPENDENT CHILDREN UNDER 21 YEARS OF AGE LIVING WITH YOU

Name of Dependent Child	Age	Name of Dependent Child	Age

Name any dependent children not at least 50% supported by you. _____

Date of injury _____ Time _____ Date injury reported _____

Accident reported to _____ By (name) _____

Who witnessed accident? _____

(Name & Address) _____

Describe fully how injury happened _____

(Continue on back if necessary)

What part(s) of your body were injured? _____

Did you stop work as a result of your accident? Yes ☐ No ☐ When? _____

Was your pay continued during any part of your disability? _____

If so, for what period? _____ Last day for which you were paid _____

If not working when do you expect to return to work? _____ If you did return what was the date? _____

From whom did you receive first medical treatment? _____ Date of treatment _____

Are you still under medical treatment? _____ How often do you receive treatment? _____

Name of doctor treating you _____

Address of doctor _____ Phone # _____

Signature _____ Date _____

Claim # _____