EMPLOYEE'S REPORT OF INJURY

PERSONAL INFORMATION

NAME | CLAIM #

ADDRESS/CITY | HOME PHONE | CELL PHONE

Gender: ❍ MALE ❍ FEMALE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

Cheboygan-Otsego-Presque Isle ESD

OCCUPATION | EMPLOYER | LOCATION

6065 Learning Lane, Indian River, MI 49749

EMPLOYER ADDRESS/CITY

NUMBER OF DAYS PER WEEK | NUMBER OF HOURS PER DAY | NORMAL DAYS OFF

LENGTH OF EMPLOYMENT | WAGES (HOURLY RATE OF PAY)

INJURY INFORMATION

DATE OF INJURY | TIME | DATE INJURY REPORTED

Accident reported to: _____ By (name): _____

Who witnessed accident (name & address for each person listed)? _____

Describe fully how injury happened (continue on back if necessary): _____

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

Did you stop work as a result of your accident? ❍ YES ❍ NO When: _____

Was your pay continued during any part of your disability? ❍ YES ❍ NO

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

If not working, date you expect to return to work? _____ If you did return to work, list date? _____

Do you plan to seek medical treatment? ❍ YES ❍ NO If yes, where? _____

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

NAME OF DOCTOR | ADDRESS/CITY | PHONE

SIGNATURE

SIGNATURE | DATE | CLAIM #

REV. 2/14/20