Independent Insurance Agent
HOTEL DIVISION

WORKERS COMPENSATION REPORTING WORKSHEET

BUSINESS / ACCIDENT INFORMATION

PHONE NUMBER / EXTENSION	TITLE	NAME	EMAIL ADDRESS	EMPLOYMENT STATE
( )				

BUSINESS NAME	BUSINESS ADDRESS (STREET, CITY, STATE & ZIP)	BUSINESS MAILING ADDRESS (STREET, CITY, STATE & ZIP) ☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER ☐ MALE ☐ FEMALE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS	DOES THE EMPLOYEE SPEAK ENGLISH? ☐ (Yes) ☐ (No)

EMPLOYEE'S HOME PHONE NUMBER ( ) EMPLOYEE'S CELL PHONE NUMBER ( )	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE ☐ FULL-TIME ☐ PART-TIME ☐ OTHER_____	REGULAR ASSIGNED DEPARTMENT	REGULAR OCCUPATION

DEPARTMENT WHEN INJURED	OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE
REGULAR WORK HOURS: HOURS/DAY _____ DAYS/WEEK _____

EMPLOYEE'S WAGE INFORMATION: $ _____ / HOUR OR $ _____ / ANNUAL OR $ _____ / WEEKLY	DOES THE EMPLOYEE WORK A VARIED SCHEDULE ☐ (Yes) ☐ (No)

DATE OF HIRE:	IF DATE OF HIRE IS UNKNOWN, WHAT IS LENGTH OF EMPLOYMENT? YEARS _____ MONTHS_____	
SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER: ( )	BEST HOURS TO CONTACT
	SUPERVISOR'S EMAIL ADDRESS:	

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER:	WAS INJURY FATAL? ☐ YES ☐ NO IF YES, DATE OF DEATH (MM/DD/YYYY) ___/___/_____	DID EMPLOYEE LOSE ANY TIME FROM WORK? ☐ YES ☐ NO

DID EMPLOYEE GET PAID FOR DAY OF INJURY ☐ YES ☐ NO	DATE EMPLOYEE LAST WORKED:	IS EMPLOYEE BACK AT WORK? ☐ YES ☐ NO	IF YES, DATE EMPLOYEE RETURNED TO WORK?

IS EMPLOYEE WORKING HIS REGULAR NUMBER OF HOURS ☐ YES ☐ NO IS EMPLOYEE ON LIGHT/ MODIFIED DUTY? ☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

ARE YOU AWARE OF ANY ISSUES THAT WOULD MAKE YOU QUESTION THIS INJURY? ☐ YES ☐ NO	IF YES, ARE YOU QUESTIONING WHETHER THIS INJURY IS WORK-RELATED? ☐ YES ☐ NO

WITNESS INFORMATION/OTHERS INVOLVED
NAME (FIRST, MI, LAST) ADDRESS PHONE NUMBER

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY)

☐ FIRST AID

DATE OF 1ST TREATMENT: _____

TREATMENT: _____

_____

☐ HOSPITAL/ CLINIC

FACILITY NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

PHYSICIAN NAME: _____

TREATMENT: _____

_____

DATE OF 1ST TREATMENT: _____

LENGTH OF STAY: _____

AMBULANCE USED? ☐ YES ☐ NO

WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO

WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT`? ☐ YES ☐ NO

☐ PHYSICIAN

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

TREATMENT DESCRIPTION: _____

_____

WHO IS THE PRIMARY CONTACT FOR THIS CLAIM?

NAME and TITLE:

PHONE NUMBER: ( )

EMAIL:

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY – STATE-SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

Email to: claims@aaatmg.com or Fax to: 803-746-4844