ELITE CLAIMS MANAGEMENT

Elite Claims Management
Workers' Compensation Specialists
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Employee's Incident Report

WHEN COMPLETING THIS FORM, PLEASE BE AS ACCURATE, SPECIFIC, AND THOROUGH AS POSSIBLE. ALL AREAS MUST BE COMPLETED – DO NOT LEAVE AREAS BLANK.

EMPLOYEE INFORMATION (PLEASE PRINT OR TYPE)

EMPLOYEE NAME _____ **EMPLOYEE #** _____ **HIRE DATE** _____ **DATE OF BIRTH** _____

DEPT/JOB TITLE _____ **EMPLOYMENT STATUS** ☐ **FULL-TIME** ☐ **PART-TIME** ☐ **TEMPORARY** ☐ **VOLUNTEER**

INCIDENT DATE _____ **TIME** _____ ☐ **AM** ☐ **PM** **DATE REPORTED** _____ **TIME** _____ ☐ **AM** ☐ **PM**

WHERE WERE YOU AT THE TIME OF THE INCIDENT?
PLEASE DESCRIBE THE LOCATION AND ENVIRONMENT (FOR EXAMPLE: INDOORS/OUTDOORS, WEATHER CONDITIONS, LIGHTING, ETC. USE ADDITIONAL SHEETS TO DRAW DIAGRAMS, IF NECESSARY).

PHYSICAL LOCATION AND ADDRESS _____
(I.E., CITY HALL, PUBLIC WORKS YARD, LIBRARY, ETC.)

WHAT PART(S) OF THE BODY WERE INJURED? BE SPECIFIC. (I.E., UPPER BACK, LOWER BACK, RIGHT KNEE, LEFT ELBOW, ETC.)

WHAT HAPPENED? (USE ADDITIONAL SHEETS IF NECESSARY.)

ACTION TAKEN TO REMEDY INJURY? (I.E., ICE, HEAT, BANDAID, ANTISEPTIC, CLEANING, ETC.)

INCIDENT DETAILS

WAS THE INCIDENT REPORTED TO YOUR SUPERVISOR IMMEDIATELY FOLLOWING ITS OCCURRENCE? ☐ **YES** ☐ **NO**
IF NOT, WHY WAS THERE A DELAY?

WHAT TOOLS AND/OR EQUIPMENT WERE YOU USING WHEN THE INCIDENT OCCURRED?
(I.E., WELDING TORCH, SCAFFOLD, JACKHAMMER, SHOVEL, COMPUTER, ETC.)

EQUIPMENT/VEHICLE # _____
(I.E., WELDING TORCH, SCAFFOLD, JACKHAMMER, SHOVEL, COMPUTER, ETC.)

IF MOTOR VEHICLE ACCIDENT, PLEASE PROVIDE POLICE REPORT NUMBER _____

DID YOU USE PERSONAL PROTECTIVE EQUIPMENT (PPE)? ☐ **YES** ☐ **NO**
IF SO, WHAT?

WERE YOU TRAINED TO PERFORM THE SPECIFIED TASK PRIOR TO THIS JOB ASSIGNMENT? ☐ **YES** ☐ **NO**
IF YES, WHEN?

PAYROLL INFORMATION

CURRENT SHIFT HOURS ☐ **4 / 10** ☐ **9 / 80** ☐ **OTHER** **CHECK REGULAR DAYS OFF** ☐ **M** ☐ **T** ☐ **W** ☐ **TH** ☐ **F** ☐ **SAT** ☐ **SUN**

CURRENT SHIFT (CHECK ALL THAT APPLY) ☐ **DAY** ☐ **SWING** ☐ **GRAVE** ☐ **A** ☐ **B** ☐ **C** ☐ **MORNING** ☐ **EVENING**

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Employee's Incident Report (continued)

PAGE TWO: EMPLOYEE NAME _____

MEDICAL INFORMATION

HAVE YOU SEEN A DOCTOR FOR THE INJURY? ☐ **YES** ☐ **NO**

IF YES, DATE? _____ IF NO, WHY NOT? _____

NAME OF PHYSICIAN AND/OR HOSPITAL _____

DID YOU MISS TIME FROM WORK AFTER THE INJURY? ☐ **YES** ☐ **NO**

IF YES, HOW LONG? _____

LAST DATE WORKED _____ DATE RETURNED _____

DID THE DOCTOR PRESCRIBE WORK RESTRICTIONS? ☐ **YES** ☐ **NO**

IF YES, BRIEFLY DESCRIBE THEM ☐ **FULL DUTY** ☐ **MODIFIED DUTY**

_____

ADDITIONAL PERTINENT INFORMATION

WAS ANYONE ELSE PRESENT WHEN THE INCIDENT OCCURRED? ☐ **YES** ☐ **NO**

IF YES, WHO? DESCRIBE THEIR INVOLVEMENT

_____

WERE OTHER EMPLOYEES INJURED WHEN THE INCIDENT OCCURRED? ☐ **YES** ☐ **NO**

IF YES, WHO?

_____

PLEASE INCLUDE ANY ADDITIONAL REMARKS OR DETAILS RELATING TO THE INCIDENT

OPTIONAL: IS THERE ANYTHING YOU WOULD LIKE TO RECOMMEND THAT MIGHT PREVENT SIMILAR INCIDENTS FROM OCCURRING IN THE FUTURE?

- **NOTE: IF YOU MISSED TIME FROM WORK YOU MUST PROVIDE A DOCTOR'S NOTE TO THE WORKERS' COMPENSATION DIVISION.**
- **SUPERVISOR PROVIDED THE EMPLOYEE WITH A DWC-1 CLAIM FORM** ☐ **YES** ☐ **NO**

I HAVE BEEN OFFERED MEDICAL TREATMENT BUT DECLINE IT AT THIS TIME. I AM AWARE THAT THIS DOES NOT CONSTITUTE A CLAIM FOR WORKERS' COMPENSATION BENEFITS. SHOULD I, AT A LATER DATE, DESIRE MEDICAL TREATMENT OR IF I LOSE ANY TIME FROM WORK DUE TO THE EFFECTS OF THIS INCIDENT, IT IS MY RESPONSIBILITY TO COMPLETE AND RETURN TO MY SUPERVISOR THE EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION (DWC-1) WHICH WAS PROVIDED TO ME WHEN I COMPLETED THIS FORM. I UNDERSTAND THAT ANY CLAIM FOR WORKERS' COMPENSATION BENEFITS MUST BE FILED BY ME WITHIN 1 YEAR OF THE DATE OF THIS INDICENT (LC 5404 & 5405).

Employee Signature **Date**

_____ _____

Supervisor's Signature **Extension** **Date**

_____ _____ _____

Supervisor's Name (Print) **Extension** **Date**

_____ _____ _____