

EMPLOYEE'S WORK INJURY AND ILLNESS REPORT

PLEASE TYPE OR PRINT

INSTRUCTIONS:

1. Complete within 24 hours of the injury.
2. Sign and date the completed report
3. Direct any questions to your agency Worker's Compensation Coordinator.

FOR AGENCY USE ONLY
Claim Number
Claim Examiner / Representative

Employee Name (as it appears on payroll)	Time of Injury	AM PM	Date of Injury
Work Telephone ()	Home Telephone ()	Social Security Number (last four) * XXX-XX-	
Was Medical Treatment Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Address of Treating Practitioner/Facility		
First aid only <input type="checkbox"/> Yes <input type="checkbox"/> No			
Time Lost From Work <input type="checkbox"/> Yes <input type="checkbox"/> No			
Last day worked (MM / DD / YY)			

Exact location of where accident took place (inside, outside, building name, room, vehicle, etc.)

Witnesses (names, addresses, work telephone numbers)

Describe in detail what you were doing when the injury /illness occurred. How exactly did it happen?

Date the injury / illness reported to my supervisor (Month, Day, Year)

Part of body injured (Check ALL that apply, and circle appropriate position)										(Thumb = Finger 1, Great toe = Toe 1)																																																	
Abdomen										Back	U	M	L							Finger	R	L	1	2	3	4	5			Head										Mouth										Shoulder	R	L							
Ankle	R	L								Eye	R	L								Foot	R	L								Knee	R	L								Neck										Toe	R	L	1	2	3	4	5		
Arm	R	L								Elbow	R	L								Hand	R	L								Leg	R	L								Nose										Wrist	R	L							
Other (Please specify)										For Hand and Arm injuries circle your dominant arm : Right Left																																																	

Have you ever been treated for a similar injury or condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes Date(s) of Treatment	Name of Practitioner, Hospital or Clinic Which Provided Prior Treatment for Similar Injury:
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Please read carefully. I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination from employment. Further I understand that the signature below authorizes medical, mental health and chiropractic providers to release all medical, mental health and chiropractic records to the State of Wisconsin, University Of Wisconsin System, Office of Safety and Loss Prevention, Worker's Compensation Department, or its designated representatives, at 780 Regent Street #145, Madison, WI 53715-2635

Employee Signature _____ **Date** _____

FOR AGENCY USE ONLY	PRIMARY ORGANIZATION CODE 1-2-85-0 - - - - -		FUND NUMBER	%	
	SECONDARY ORGANIZATION CODE 1-2-85-0 - - - - -		FUND NUMBER	%	
LOSS DESCRIPTION CODES	CAUSE / OCCURRENCE	OBJECT	RESULT	LOCATION	OCCUPATION
OSHA CODES					
Incident was OSHA "recordable"? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Authorized Representative				Date	

*Your Social Security Number must be provided and will be used for positive identification in the processing of any claims.