

ACCIDENT NOTIFICATION

**Required fields*

INJURED PERSON'S INFORMATION

*First Name: _____ M.I.: _____

*Last Name: _____ Suffix: _____

*Gender: _____

*Home Address: _____
*Street _____ *City _____

*State _____ *Zip _____

Phone: _____

*SSN: _____ *DOB: _____

Occupation Description:

Budget Dept. Code: _____

INJURY AND MEDICAL TREATMENT

*Date of Injury: _____ Time of Injury: _____

*Date Employer Notified: _____

Witness Name: _____ Witness Phone: _____

*Accident/Injury
Description:

Accident Location: _____

*Medical
Treatment Received: _____

WORK STATUS

Has Employee Returned to Work?: Yes / No Initial Return to Work Date: _____

*Est. Weekly Wage: \$ _____ Employment Status: _____

Employer Paid Salary in Lieu of Comp?: Yes / No Check if Returned to Work with Physical Restrictions:

Supervisor Name: _____ Supervisor Phone: _____

FOR VOLUNTEER WORKERS ONLY - REGULAR EMPLOYER INFORMATION

Regular Employer Name: _____

Volunteer Firefighter or
Volunteer Ambulance: _____