TELEPHONE REPORTING OF WORKERS' COMPENSATION CLAIMS
INFORMATION NEEDED

Employer: _____Email: _____

Employer Address: _____
Street, P.O. Box *City* *State/Zip code*

Employer Phone Number: (___)_____ Person Filling Out Report: _____

Claimant Full Name: _____

Claimant Address: _____
Street, P.O. Box *City* *State/Zip code*

Claimant Phone Number: (___)_____ Claimant Social Security #: _____

Claimant Date of Birth: _____ Claimant Date of Hire: _____

Claimant Job Title: _____ Claimant Marital Status: _____

Claimant Supervisor: _____

Date of Accident: _____ Time: _____ a.m. or p.m.

Date Employer Knew of Accident: _____

Date Dr. Took Claimant Off of Work: _____ Last Date Paid: _____

Where Accident Occurred: _____

What Employee Was Doing When Injured: _____

_____

What Part of Body & How Injury Occurred: _____

_____

_____

Witnesses: _____

Wage Information: Hourly _____ Full Time _____ Part Time _____ Seasonal _____

Rate of Pay: _____/Hour or Guaranteed Salary _____ per week month year
Circle one above

Expect a telephone call from the Claims Division, as additional wage information may be required.

Medical Facility Name: _____ Phone #: (___)_____

Medical Facility Address: _____
Street, P.O. Box *City* *State/Zip code*

Doctor Treating Injury: _____

Drug Screen: Yes ( ) No ( ) If no, why?_____

ONCE YOU HAVE ALL OF THE ABOVE INFORMATION, PLEASE FAX TO
318-329-8894 OR CALL 1-800-579-0202

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