EMPLOYEE’S REPORT OF INJURY

Dear Claimant:

We have received a report that you were injured in the course of your employment. In order for us to process your claim efficiently, please fill in all lines completely and print legibly. Attach additional sheets if necessary.

1. Name: _______________________________ Social Security: _______________________________
   LAST                  FIRST                  MI                  MAIDEN

2. Give your current home address: __________________________________________________________

3. By whom are you employed? _____________________________________________________________

4. What is your job title/description? _______________________________________________________

5. What are your monthly wages? ____________________________________________________________

6. How many days per week do you work? ____________________________________________________

7. On what date were you injured? _______________ Time: _______________

8. What was the exact location of the accident (street address if possible)? _________________________

9. How did the accident happen? ____________________________________________________________

   _____________________________________________________________________________________

   _____________________________________________________________________________________

10. What part of your body was injured? _______________________________________________________  

11. When did you report the accident? ________________________________________________________

12. To whom did you make your accident report? _______________________________________________

13. List name(s), address(s), and telephone number(s) of witness or witnesses: ___________________________

   _____________________________________________________________________________________

14. Name, address, and telephone number of physician who provided treatment: ___________________________

   _____________________________________________________________________________________

15. When did you first receive treatment? _______________________________________________________

16. When did you stop working as result of your accident? _________________________________________

17. Name, address, and telephone number of doctor presently treating you: ___________________________

18. When were you last treated? __________________________________________________________________

19. Have you returned to work? ______ If so, when? _______________________________________________

20. Have you lost any wages on account of your accident? __________________________________________

21. Have you ever had a previous injury claim? ______ If so, describe: ________________________________

   _____________________________________________________________________________________

   _____________________________________________________________________________________

(dated)__________________________________________  (signed)___________________________________________

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