

# EMPLOYES'REPORT OF INJURY

#### DearEmployee

We received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all line completely and print legiblyAttach additional sheets if necessary.

Name:				Social Securit <u>y:</u>		GendeM	F
Last Address:	First	MI. Maiden Date of Injury:					
City:				Employer:			
Primary Phone Number:				Job Title:			
Secondary Phone Number:				Work Schedule:			
Email address:				_			
1) What was the exa	ct location of th	ie accid <b>êrin</b> c	lude street addr	ess if possible			
2) What was happen	ing at the time?	? What was (	going on around	you, what were y	you doing, wh	at were other people d	oing
3) Briefly describe w	hat exactly cau	sed the injur	y:				
4) Whatareas of you	r body werienjur	ed?					
5) When and towhom did you report your injury Date							
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# Instructions Employee's Report of Injury

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#### Purpose of Form:

The injured employee completes this form to provide the State Office of Risk Managenesis Managenesis with information pertaining to the circumstances surrounding the injury and what has happened since the date of higher to help expedite benefits.

## Filing Deadline:

The form must be received by SORM not later than the 5th calendar day aftershereport of Injury or Illness Form (DWG1S) is reported by the agency.

## Completed by:

This form shall be completed by the injured employee with assistance from the Claims Coordinator, if needed.

#### Instructions:

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