RISK ADMINISTRATION SERVICES, INC.

EMPLOYEE INJURY REPORT

Claim No.:

INJURED WORKER INFORMATION

Last Name:	First Name:	MI:	Date of Birth:	SSN:

Address:	City:	State:	Zip:

Marital Status: ☐ Married ☐ Unmarried	Gender: ☐ Male ☐ Female	Dependents:	Phone:	Email:

EMPLOYMENT INFORMATION

Employer:	Employer Address:	Yrs employed:

At the time of injury were you employed anywhere else? (**If yes please fill out the following**):

Employer Name: Address: Duties:

Name and address of your former employers:	Have you ever filed a Workers' Compensation claim? ☐ Yes ☐ No When: Employer:

INJURY INFORMATION

Date of Injury:	Time of Injury: ☐ AM ☐ PM	Date you reported injury:	Name/title of person you reported to:

Describe how and what happened to cause this injury:	Where were you when injury occurred?

Name all injuries from this accident:

Have you ever suffered any injuries either work or non-work related before? ☐ Yes ☐ No (**If yes please explain):**

Are you working? ☐ Yes ☐ No	Did you miss work? ☐ Yes ☐ No	Were you paid for any part of time lost? ☐ Yes ☐ No	Date(s) of lost time:

Witnesses:	**TRUCKING ONLY:** Where did your Employer administer your Qualification Tests? **City/State**

Was your injury the result of someone else's negligence? ☐ Yes ☐ No **(If yes, please fill out the following):**

Name:_____ Address:_____ Phone: _____

Insurance Co.:_____ Policy or Claim No.: _____

TREATMENT INFORMATION

Date of first medical treatment:	Are you still under a Dr's care? ☐ Yes ☐ No	Date of most recent treatment?	Are you covered by your spouse's ☐ Yes ☐ No health insurance?

Name and Addresses of all doctors and hospitals treating you:

Have you had previous problems or treatments to this body area(s) ☐ Yes ☐ No **(If yes, please describe and include dates experienced):**	Please list name/address of Group Health Ins:

Employee Signature:	**Date:**

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