



THE MCINTYRE GROUP
INSURANCE BROKERS & CONSULTANTS

WORKER'S COMPENSATION REPORTING WORKSHEET
DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT / ACCIDENT INFORMATION			
CALLER'S PHONE #EXT	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE, & ZIP)	SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME	
DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED			
PARENT COMPANY/INSURED'S NAME			
LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS	
DATE OF INJURY	TIME OF INJURY		
ACCIDENT DESCRIPTION			
EMPLOYEE INFORMATION			
INJURED EMPLOYEE'S SSN	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS		
EMPLOYEE'S HOME PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)		
EMPLOYEE JOB INFORMATION			
EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____	INJURED WORKER TYPE	REGULAR OCCUPATION	
OCCUPATION WHEN INJURED			
EMPLOYEE'S WORK SCHEDULE			
REGULAR WORK HOURS	HOURS/DAY	DAYS/WEEK	
EMPLOYEE'S WAGE INFORMATION			
\$ _____ /HOUR OR \$ _____ /ANNUAL OR \$ _____ /WEEKLY OVERTIME: \$ _____ ADDITIONAL BENEFITS: \$ _____			
DATE OF HIRE OR LENGTH OF EMPLOYMENT			
SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	BEST HOURS TO CONTACT:	
ACCIDENT INFORMATION			
DATA CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK	
RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO	
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)			
EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED			
DO YOU QUESTION THE VALIDITY OF THE CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO			
WITNESS INFORMATION/OTHERS INVOLVED			
NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER	



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INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

YES NO

TREATMENT ("X" ALL THAT APPLY)

<input type="checkbox"/> FIRST AID	TREATMENT AND DATE OF 1 ST TREATMENT	
<input type="checkbox"/> HOSPITAL/CLINIC	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN TIME, TREATMENT, DATE OF FIRST TREATMENT, LENGTH OF STAY, AMBULANCE USED?	
	WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PHYSICIAN		

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION