

Workers Compensation First Report of Accident

Company Name:

Policy Number _____ Claim Number _____

Employee Name: _____ Date: _____

Address: _____

SSN: _____ Gender: _____ Full Time or Part Time

Marital Status: _____ Date of Birth _____

Home Phone Number: _____ Pay Rate: _____

Occupation / Job Title: _____ Date of Hire _____

Date of Injury: _____ Time of Injury: _____ A.M. or P.M

Full Pay for Date of Injury No ____ Yes ____

Describe work employee was performing at time of accident:

Describe where and how accident occurred:

Were there any witnesses who actually saw the accident? No ___ Yes ___
Who? _____

Witnesses phone # _____

Part of body injured: _____

Was injury related to a previous injury? _____

Medical Treatment:

- First aid on premises
- Professional medical treatment
- Hospitalization

Employee Work Released For:

- Regular duty on _____
- Restricted duty _____
- Off-work, re-check on _____

Treatment given by: _____

Address: _____

Was immediate corrective action taken? No ___ Yes ___
If yes, what? _____

Did you ever notify your immediate supervisor about the problem? No ___ Yes _____. If
yes, when? _____ More than once No ___ Yes _____

Did you ever notify your HR department? No ___ Yes ___ If yes, when? _____

Additional action taken / comments: _____

Report By: _____ Reviewed By: _____

Site Safety Supervisor

Date: _____

Date: _____

**Please fax completed form to Claims 619-461-2456 or you may email
to Claims@bhiservices.com. If you have any questions please call
619-461-6022.**