



Report of Accident (Workplace Injury, Accident or Occupational Disease)

Language preference (check one) <input type="checkbox"/> English <input type="checkbox"/> Español/Spanish <input type="checkbox"/> русский/Russian <input type="checkbox"/> Tiếng Việt/Vietnamese <input type="checkbox"/> 繁體中文/Chinese Traditional <input type="checkbox"/> 简体中文/Chinese Simplified <input type="checkbox"/> 한국어/Korean <input type="checkbox"/> ខ្មែរ/Cambodian <input type="checkbox"/> Soomaali/Somali <input type="checkbox"/> Other: _____										Claim No. _____	
1. Name (First-Middle-Last)			2. <input type="checkbox"/> Male <input type="checkbox"/> Female		14. Date of injury or last occupational exposure / /		15. Time of injury: : : <input type="checkbox"/> AM <input type="checkbox"/> PM		16. Shift (check one) <input type="checkbox"/> Day <input type="checkbox"/> Swing <input type="checkbox"/> Night		
3. Social Security Number			4. Home phone ()		5. Birth date month / day / year		17. Have you ever been treated for the same or similar condition? <input type="checkbox"/> YES <input type="checkbox"/> NO		18. Is this condition due to a specific incident? <input type="checkbox"/> YES <input type="checkbox"/> NO		
6. Home address			7. Height (FT-IN.)		8. Weight		19a. Body parts injured or exposed:		19b. Describe in detail how your injury or exposure occurred. (Include tools, machinery, chemicals or times that may have been involved)		
9. Mailing address (if different from home address)			10. Family status: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Registered Domestic Partner		20. Were you doing your regular job? <input type="checkbox"/> YES <input type="checkbox"/> NO		21. Where did the injury or exposure occur? <input type="checkbox"/> Employer Premises <input type="checkbox"/> Jobsite <input type="checkbox"/> Other:		22. Where did the injury/exposure occur? Name of business:		
11. Dependent children (Include unborn/estimate birth date. Benefits will be based in part on number of legally dependent children. If you don't have legal custody, complete Box 13.)			12. Name of Spouse or Registered Domestic Partner:		23. Injury caused by a faulty machine, product or person other than my employer or co-worker? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> POSSIBLY		24. List any witnesses:		25. When will you return to work? / /		
13. Name & address of children's legal guardian			26. When did you last work? / /		27. Did you report the incident to your employer? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. Date you reported it: / /		29. Did you have employer-paid health care benefits on the day injured? <input type="checkbox"/> YES <input type="checkbox"/> NO		
30. Business name of your employer			31. Type of business		32. How long have you worked there? Years Months Weeks Days		33. Employer's phone ()		34. Your employer's address		
35. List your job title and describe your job duties			36. Rate of pay at this job (check one) <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> More than 1 rate of pay		37. Hours per day		38. Days per week		39. Additional earnings (daily average) (check all that apply) <input type="checkbox"/> Tips <input type="checkbox"/> Shift diff. <input type="checkbox"/> Piece work <input type="checkbox"/> Regular overtime <input type="checkbox"/> Commission <input type="checkbox"/> Bonuses in the last 12 months		
40. How many paying jobs do you have?			41. I am a: <input type="checkbox"/> Corp. Shareholder <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Corp. Director <input type="checkbox"/> Optional Coverage <input type="checkbox"/> Corp. Officer <input type="checkbox"/> Does not apply to me		42. Signature I declare these statements are true to the best of my knowledge and belief. In signing this form, I permit health care providers, hospitals, or clinics to release relevant medical reports, which they or others produce, to the Dept. of Labor & Industries.		43. Signature I authorize the Department of Labor & Industries, or others acting on their behalf, to obtain confidential employment records from the Employment Securities Department (ESD) to assist in determining workers' compensation benefits.		Today's date / /		

1. Diagnosis		2. ICD Codes		3. Patient's ID number, if available:		Claim No. _____	
4. Is the condition due to a specific incident? <input type="checkbox"/> YES <input type="checkbox"/> NO		5. Objective findings supporting your diagnosis (include physical, lab and X-ray findings)		7. Was the diagnosed condition caused by this injury or exposure? Check one. <input type="checkbox"/> YES <input type="checkbox"/> PROBABLY (51% or more) <input type="checkbox"/> NO <input type="checkbox"/> POSSIBLY (Less than 50%)		8. Will the condition cause the patient to miss work? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, estimate the number of days: _____	
6a. Is more treatment needed? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> POSSIBLY		6b. Treatment and diagnostic testing recommendations:		9. Is there any pre-existing impairment of the injured area? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, describe briefly or attach report.		10. Has patient ever been treated for the same or similar condition? If YES, provider name, city & year: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. Name of attending health care provider (Please print) Name		12. Did you refer the patient to an L&I medical network provider for follow-up? Referred to: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO Name Phone ()		13. IMPORTANT: L&I Provider Number or NPI of provider listed in Box 13.		14. This exam date / /	
15a. Name of hospital or clinic where patient was treated: Name		15b. This exam date / /		15c. Phone		15d. Phone	