Incident Report Form- Employee Statement

8401 Lake Worth Rd Suite 2-232 Lake Worth, FL 33467
Voice: 888-616-2315 Fax: 561-404-8095

All Claims Must be Reported Within 24 Hours of Occurrence!
Any Injured Employee Should Seek Medical Treatment as He/She Feels Necessary.

EMPLOYEE INFORMATION

Employee SSN:

First Name:

Last Name:

Current Mailing Address:

City: State: Zip:

Marital Status:

Male: Female:

Current Phone Number: Date of Birth: Gender:

Title: Unit: Full-Time or Part Time

INCIDENT DETAIL

Date of Injury: Time Of Injury:

Date and Time I.H.S. was Notified:

Who did you notify:

How did you contact *I.H.S.*? Email, phone, text

Start Time on the Day of Injury:

Normal Scheduled Hours: On Date of Injury Did you complete your shift? Yes or No

Location of Incident:

Unit/Floor:

Witness: Witness Phone Number:

Was this incident reported to anyone at the facility? If so, whom?

Accident Description

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Automobile Accidents Only

Has this accident been file with your Auto-Insurance Carrier? Yes No

If not, will you be filing a claim with your Auto Insurance Carrier? Yes No

Please provide Auto-Insurance Carrier:

Policy Number:

Injured Body Part/Location - Please be specific (right hand, ring finger):

Were safety devices in place? Yes No

Please describe:

INITIAL MEDICAL TREATMENT

Medical Facility Name:

Medical Facility Address:

City: State: Zip:

Physician Name:

Medical Facility Phone Number:

Medical Facility Fax Number:

Any Loss of Time? Yes No

If yes, number of days and/or hours?

Last day present at work?

Date returned to work?

Employee Signature: **Date:**

Please fax complete forms to *I.H.S.* at 561-404-8095 – Attn: Human Resources