SCF Arizona™
and its subsidiary companies

SCF ARIZONA AND ITS SUBSIDIARY COMPANIES
P.O. Box 33069 | Phoenix, AZ 85067-3069 | 602.631.2300 | 800.231.1363

Date: _____

Select Your Insurer
☐ SCF Arizona
☐ SCF American Insurance Company
☐ SCF Casualty Insurance Company
☐ SCF General Insurance Company
☐ SCF Indemnity Insurance Company
☐ SCF National Insurance Company
☐ SCF Premier Insurance Company
☐ SCF Western Insurance Company

WORKERS' REPORT OF INJURY AND RELEASE OF MEDICAL INFORMATION

	CLAIM NUMBER	DATE INJURED	
	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	
	BIRTH DATE	SEX ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Married
	IF MARRIED, IS SPOUSE EMPLOYED? ☐ YES ☐ NO		
	ARE YOU ☐ RIGHT OR ☐ LEFT HANDED?		
	LAST DAY WORKED (MO/DAY/YR)		
IF NO PHONE OR STREET ADDRESS, HOW CAN YOU BE LOCATED?	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	DATE RETURNED TO WORK (MO/DAY/YR)	

TREATMENT RECEIVED

NAME OF DOCTOR WHO EXAMINED YOU	ADDRESS OF DOCTOR WHO EXAMINED YOU	CITY	STATE	ZIP CODE
DATE OF FIRST TREATMENT (MO/DAY/YR)	DATE OF LAST TREATMENT (MO/DAY/YR)	STILL UNDER TREATMENT? ☐ YES ☐ NO		
IF TREATED IN EMERGENCY ROOM — NAME OF HOSPITAL	NAME OF PHYSICIAN	DATE TREATED (MO/DAY/YR)		
IF TREATED IN A GOV'T OR V.A. HOSPITAL — NAME OF HOSPITAL		DATE TREATED (MO/DAY/YR)		

INJURY INFORMATION

DESCRIBE FULLY HOW YOUR INJURY HAPPENED

PARTS OF BODY YOU INJURED

HOUR OF INJURY ☐ AM ☐ PM	ADDRESS OR LOCATION WHERE INJURED
DATE YOU REPORTED INJURY (MO/DAY/YR)	NAME OF SUPERVISOR INJURY REPORTED TO

IF INJURY REPORTED LATE, GIVE REASON FOR DELAY

WITNESS TO YOUR INJURY: GIVE FULL NAME AND ADDRESS. IF NO WITNESSES, WRITE NONE.

IF INJURY CAUSED BY ANOTHER PERSON GIVE FULL NAME AND ADDRESS

OCCUPATIONAL DATA

EMPLOYER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE
OCCUPATION AT TIME OF INJURY	WERE YOU EMPLOYED ELSEWHERE AT TIME OF INJURY? ☐ YES ☐ NO	**LIST EMPLOYMENT DATA ON PAGE 2**	

AT TIME OF INJURY WERE YOU A CONTRACTOR, SUBCONTRACTOR, OR WORK FOR OTHER THAN WAGES? ☐ YES ☐ NO

DATE HIRED	NUMBER OF DAYS WORKED PER WEEK	NUMBER OF HOURS WORKED PER DAY	HOURLY WAGE $	MONTHLY SALARY $

GENERAL INFORMATION

EDUCATION (ENTER LAST GRADE COMPLETED)	GRADE SCHOOL (1 2 3 4 5 6 7 8)	HIGH SCHOOL (9 10 11 12)	COLLEGE (13 14 15 16)
YEAR YOU BECAME ARIZONA RESIDENT	STATE YOU MOVED FROM	VALID DRIVER'S LICENSE? ☐ YES ☐ NO	

LIST FULL NAMES AND ADDRESSES OF PERSONS DEPENDENT ON YOU FOR SUPPORT

SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY NUMBER

IMPORTANT ALL THREE PAGES OF THIS FORM MUST BE COMPLETED AND SIGNED PREVENTING DELAY TO ANY BENEFITS TO WHICH YOU MAY BE ENTITLED.

LIST MAJOR INJURIES, MEDICAL CONDITIONS, OR ILLNESSES BELOW

DATE OF INJURY OR DIAGNOSIS (MO/DAY/YR)	DESCRIBE INJURY, CONDITION, OR ILLNESS (BROKEN LEG, HERNIATED DISC, DIABETES, HEART DISEASE, ETC.)	TYPE OF INJURY/ CONDITION ☐ INDUSTRIAL ☐ NON INDUSTRIAL	CLAIM DISPOSITION ☐ NO CLAIM ☐ CLAIM DENIED ☐ CLAIM ACCEPTED	IF CLAIM ACCEPTED GIVE TYPE & DATE OF FINAL SETTLEMENT. IF CONDITION RATED, GIVE PERCENTAGE OF PERMANENT DISABILITY NAME OF INSURANCE COMPANY
DATE OF INJURY OR DIAGNOSIS (MO/DAY/YR)	DESCRIBE INJURY, CONDITION, OR ILLNESS (BROKEN LEG, HERNIATED DISC, DIABETES, HEART DISEASE, ETC.)	TYPE OF INJURY/ CONDITION ☐ INDUSTRIAL ☐ NON INDUSTRIAL	CLAIM DISPOSITION ☐ NO CLAIM ☐ CLAIM DENIED ☐ CLAIM ACCEPTED	IF CLAIM ACCEPTED GIVE TYPE & DATE OF FINAL SETTLEMENT. IF CONDITION RATED, GIVE PERCENTAGE OF PERMANENT DISABILITY NAME OF INSURANCE COMPANY
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MILITARY SERVICE (BRANCH, DATES SERVED AND DUTIES)

ARE YOU NOW RECEIVING DISABILITY COMPENSATION OR PENSION FROM ANY SOURCE (INCL. SOC. SEC.)? ☐ YES ☐ NO	IF “YES,” AMOUNT RECEIVED $ PER WK MO YR	
DATE OF INJURY	TYPE OF INJURY/CONDITION	CLAIM NUMBER
NAME AND ADDRESS OF INSURANCE COMPANY		

EMPLOYMENT INFORMATION FOR TWELVE (12) MONTHS BEFORE INJURY
(LIST CURRENT EMPLOYER FIRST, THEN THE EMPLOYER BEFORE THAT, ETC., AND PERIODS OF UNEMPLOYMENT)

EMPLOYER NAME AND ADDRESS (SHOW UNEMPLOYMENT COMPENSATION PERIODS AND GROSS AMOUNT RECEIVED)	TYPE OF WORK & EMPLOYMENT DATES		GROSS EARNINGS BEFORE DEDUCTIONS
1. CURRENT EMPLOYER	TYPE OF WORK		$
ADDRESS	FROM	TO	
2.	TYPE OF WORK		$
	FROM	TO	
3.	TYPE OF WORK		$
	FROM	TO	
4.	TYPE OF WORK		$
	FROM	TO	
IMPORTANT - FILL IN TOTAL INCOME FOR TWELVE (12) MONTHS BEFORE INJURY			$

REMARKS

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE.

DATE AND SIGNATURE MUST BE FILLED IN BEFORE MAILING	DATE SIGNED	SIGNATURE

SCF Arizona
and its subsidiary companies

3030 N. 3rd Street, Phoenix, AZ 85012-3068

www.scfaz.com

Claimant: _____ Claim Number: _____

Social Security Number: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION

By this authorization or reproduction thereof, I hereby authorize and request any person or organization to allow SCF Arizona or its authorized representative to examine, discuss and copy any information, records, reports and x-rays regarding my medical condition, treatment and employment history.

Disclosure of medical records for the purpose of administration of workers' compensation claims is authorized by the Health Insurance Portability and Accountability Act (HIPAA), § 42 C.F.R. § 164.512.

Date: _____ Claimant's Signature: _____

Address: _____
Street City State Zip

Witnessed: _____