

**Worker's Comp Incident Form**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Name of Compensation Carrier: \_\_\_\_\_.

Name of Employer: \_\_\_\_\_.

The date of the work related injury was: \_\_\_\_\_.

The time that the injury occurred was: \_\_\_\_\_ a.m. / p.m.

The last date worked was: (month)\_\_\_\_\_/ (day)\_\_\_\_\_/ (year)\_\_\_\_\_.

Were you hospitalized?  Yes  No. If yes, please answer the questions below.

When were you hospitalized?  immediately  later same day  next day  date \_\_\_\_\_

How were you transported to the hospital?  ambulance  life flight  private transportation

What did the hospital recommend?  no instructions  see this clinic  see DC  
 see own doctor  see orthopedist  see neurologist  prescription medication  
 other: \_\_\_\_\_

Did you have any xrays taken?  Yes  No

If yes, what areas? \_\_\_\_\_

My current job status is: (please mark the appropriate response below)

- off work as a result of the injuries sustained in the reported work accident.
- working full duty.
- working light duty.

I  have  have not been involved in previous work related accidents/injuries.

If you have been involved in previous work related accidents/injuries, please complete below.

Status of previous injuries:

- treated and resolved
- treated, unresolved, and located at an unrelated area to this accident
- treated, unresolved, same area as current injury
- not treated and a completely different area than current injury
- not treated and still have residual symptoms
- not treated and do not have any residual symptoms

This accident was:  not reported to the employer.  reported to the employer.

The name of the employee it was reported to was: \_\_\_\_\_.

Employee's Job Title \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_.

The injury occurred at (location): \_\_\_\_\_.

How many hours did you work that same day prior to the accident: \_\_\_\_\_.

What type of work were you performing at time of injury: \_\_\_\_\_  
\_\_\_\_\_.

Describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

I have:

- been treated by another doctor for the injuries sustained in this accident.
- not been treated by another doctor for the injuries sustained in this accident.

If you have been treated by another doctor, please continue with the following questions.  
List the doctor's name and current/past treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

As a result of the treatment received thus far:

- My condition has improved
- My condition has not improved
- My condition has worsened since the injury despite treatment received thus far.