FIRST REPORT OF INJURY

COMPANY NAME: Click here to enter text.

**Date of Injury:** Click here to enter text. **Time of Injury:** Click here to enter text.

**Address Accident Occurred:** Click here to enter text.

**Scheduled Shift for Day of Accident:** Click here to enter text.

**Did employee lose any time from work due to accident?** Yes [ ]  No [ ]

**Has employee returned to work?** Yes [ ]  No [ ]  **If yes, date returned:** Click here to enter text.

**Injured Person:**

 **Name:** Click here to enter text. **Male** [ ]  **Female** [ ]

 **Address:** Click here to enter text. **City:** Click here to enter text.

 **State:** Click here. **Zip Code:** Click here. **Email:** Click here to enter text.

 **Phone No.:** Click here to enter text. **DOB:** Click here to enter text.

**SSN:** Click here to enter text. **Martial Status:** Click here to enter text.

 **Full-Time:** [ ]  **Part-Time:** [ ]  **Date of Hire:** Click here to enter text.

 **Occupation:** Click here to enter text.

**Full Description of Accident:** Click here to enter text.

**Part of Body Injured:** Click here to enter text.

**Nature of Injury:** Click here to enter text.

**Names of Witnesses:** Click here to enter text.

**Where taken:** Click here to enter text.

**Physician:** Click here to enter text.

**Treatment:** Click here to enter text.

**Restrictions:** Click here to enter text.

**Company Contact:** Click here to enter text.

**Contact Phone & Email:** Click here to enter text.

**Follow-Up Appointment Scheduled?** **Yes** [ ]  **No**[ ]  **When?** Click here to enter text.

*Email form to info@horakinsurance.com*