

CCMSI**EMPLOYEE'S REPORT OF INJURY**

Name _____ Claim # _____
Address _____
Occupation _____ Date of Birth _____ Soc. Sec. # _____
Sex _____ Married or Single _____ Employer _____
Employer's Address _____
Department _____ No. days/week _____ Normal days off _____
Length of employment _____ Wages (hourly rate of pay) _____ Number hours worked/day _____

COMPLETE THE FOLLOWING IF YOU HAVE DEPENDENT CHILDREN UNDER 21 YEARS OF AGE LIVING WITH YOU

Name of Dependent Child	Age	Name of Dependent Child	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name any dependent children not at least 50% supported by you. _____

Date of injury _____ Time _____ Date injury reported _____
Accident reported to _____ By (name) _____
Who witnessed accident? _____
(Name & Address) _____
Describe fully how injury happened _____

(Continue on back if necessary)

What part(s) of your body were injured? _____
Did you stop work as a result of your accident? Yes ☐ No ☐ When? _____
Was your pay continued during any part of your disability? _____
If so, for what period? _____ Last day for which you were paid _____
If not working when do you expect to return to work? _____ If you did return what was the date? _____

From whom did you receive first medical treatment? _____ Date of treatment _____
Are you still under medical treatment? _____ How often do you receive treatment? _____
Name of doctor treating you _____
Address of doctor _____ Phone # _____

Signature _____ Date _____
Claim # _____