LYONS COMPANIES

Carrier: _____
Policy #: _____
Effective Date: _____

WC Incident Report Form

Employer/Insured: _____

Insurance Carrier: _____ Policy #: _____

Form to be completed by immediate supervisor on duty

NOTE: Completion of this report does not imply liability. It is company policy to record the details of any accident, injury or incident.

EMPLOYEE INFORMATION

Name: _____ Sex: _____ SS#: _____-_____-_____

Address: _____

Apt Number: _____ City: _____

County: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Secondary Phone Number: _____

Date of Birth: _____ Age: _____ Martial Status: _____ # Dependents: _____

Occupation: _____ Department Employed:_____

Date Hired: _____ State Hired: _____ Weekly hours: _____ Salary:_____

EMPLOYER INFORMATION

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Nature of Business: _____

Contact Person for First Report:_____

Address of contact person (if different from above):_____

City: _____ State: _____ Zip Code: _____

Supervisor: _____ Phone Number: _____

DESCRIPTION OF INCIDENT

Date of Incident: _____ Normal Starting Time: _____ Time of Incident: _____

Date Employer knew of injury: _____

Exact Location: _____

What was the injured person doing at the time of the incident: _____

_____

Type of injury: _____ Body part injured: _____

Department or location which incident occurred: _____

List equipment or materials the employee was using at the time of the incident:

_____

Was there supervision at the time of the incident? Yes _____ No _____

If yes, by whom? _____

What was the supervision? _____

Please give a detailed description of the incident:_____

_____

_____

_____

Was First Aid administered? Yes _____ No _____ By whom? _____

What treatment was used? _____

For how long? _____

Has employee returned to work? Yes _____ No _____ Date employee returned: _____

Was CPR used? Yes _____ No _____ For how long? _____

Was police or ambulance called? Yes _____ No _____ Time of Arrival: _____

Action taken by police or EMS: _____

Referred to hospital or doctor? Yes _____ No _____

Did they go to hospital or Doctor? Yes _____ No _____

What hospital or doctor were they referred to? _____

Address: _____

City: _____ State: _____ Zip Code: _____

If injured employee was a minor, was a guardian notified? Yes _____ No _____ When: _____

If not notified, explain why: _____

Name of staff assisting in incident: _____ Position:_____

Witnesses: Please list ALL witnesses:

(1) Name: _____ Phone: _____

Address_____

(2) Name: _____ Phone: _____

Address_____

(3) Name: _____ Phone: _____

Address_____

Additional Comments:

_____

_____