CIRMAcare INJURY REPORTING HOTLINE

1-800-652-4762 (24 HOURS)

LOSS INFORMATION

Loss Date: _____ Loss Time: _____ Call Type: Claim ☐ Occurrence ☐

Caller's First & Last Name _____ Caller's Telephone Number _____

Injured Employee's Employment Status: Full Time Part Time Volunteer Other

Loss Location Name: _____

Loss Location Address: _____ City & State _____ Zip Code _____

INJURED EMPLOYEE'S INFORMATION

Employee's First & Last Name _____

Employee's Home Address; _____ City & State _____ Zip Code: _____

Employee's Telephone Numbers: Work: _____ Home: _____

Gender: Male Female Date of Birth: _____ Job Title: _____

Department: _____

Supervisor's Name: _____ Telephone Number: _____

Employee's Hire Date: _____

Did employee miss work beyond normal shift? Yes No If Yes, continue below

Last Day worked: _____ Disability Date: _____ Returned to Work: _____

Time Employee Began Work: _____ Date Employer Notified: _____

Loss Description: _____

Injury Type: _____ Cause of Injury: _____ Body Parts Involved _____

Contact Name: _____ Telephone Number _____

TREATMENT INFORMATION (If Known)

Name of Physician: _____ Physician's Telephone Number: _____

Name of Hospital: _____ Hospital Telephone Number _____

WITNESS

Name: _____ Address: _____

City & State: _____ Zip Code: _____ Telephone Number: _____