FORTUNE
Business Solutions
innovative HR outsourcing

Workers' Compensation Incident Report

Company Name _____ Self Insured Number _____

Address _____ City/ State/ ZIP code _____

Employee Name _____ Social Security Number _____

Address _____ City/ State/ZIP code _____

Date of Injury _____ Occupation _____

Time of Injury _____ A.M. _____ P.M. Date Reported to Employer _____

Witness Name(s) (if any please fill out witness statement form) _____

_____

_____

Location injury occurred if different from company location _____

_____

_____

Address _____ City/State/ZIP code _____

Description of injury - describe in detail (E.G.,slip and fall occurred,substances involved such as oil, water, etc.)

_____

_____

_____

Give the exact nature of injury and part of body affected (E.G., laceration of the right index finger, etc.)

_____

_____

_____

Was first aid given to employee at company location? Yes No

Did employee receive outside medical treatment? Yes No

Give name of hospital, clinic and/or physician's name _____

_____

_____

_____

Last date employee worked _____

Date employee returned to work (if known) _____

Did the injury result in death? Yes No

Employee's signature _____ Employer's signature _____

Date _____ Date _____

Please Return to Fortune Business Solutions
Fax: (813) 754-1975