7710 INSURANCE
a Trean Company

WORKERS' COMPENSATION INJURY NOTICE

(To be filled out by employee)

Fire District: _____

Date of Injury:_____ Time of Injury:_____

Injured Worker's Name:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Telephone Number:_____ Social Security Number:_____

Employee Date of Birth:_____ Email:_____

☐Male ☐ Female ☐ Married ☐ Single _____ # Dependents _____ Avg Weekly Wage

Date of Hire_____ Last Day Employee Worked _____

Where did the accident occur:_____

Address of accident:_____

Supervisor to whom you report:_____

Any Witnesses: ☐ Yes ☐ No IF YES, Who_____

Please describe the accident. (Include events leading up to the injury and any objects or substance involved.)

_____

_____

_____

_____

Describe Injury:_____

_____

Did you seek medical attention: ☐ Yes ☐ No

If "YES" Where did you seek medical attention: _____

Physician Name, Address and Telephone Number: _____

_____

How can you avoid and accident in the future:_____

_____

How can the fire district help to avoid this type of accident:_____

_____

_____

I, the undersigned injured worker, or legal representative of the injured worker named above, do hereby certify that the information provided is complete, true and correct to the best of my knowledge and that I have provided that information in order to obtain the benefits provided for by all applicable codes and rules. I hereby authorize any physician, chiropractor, practitioner, or other person, any hospital, including Veteran's Administration or other governmental hospital, any medical service organization, any insurance company, or other entity or organization, governmental or private, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or any other disabilities or injuries. A photocopy of this authorization shall be as valid as the original.

_____

Signature Date

PRIOR HISTORY

_____ I have **NO** prior conditions, injuries, or disabilities, of which I am aware, that might affect the disposition of the claim referenced above. If you checked this box, no further information is needed at this point.

_____ I have a prior condition, injury, or disability that could affect the disposition of the claim referenced above (this can include birth defects, prior surgeries, injuries, etc. whether work related or not). If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary.

_____

_____