TO BE COMPLETED BY EMPLOYEE

WORKERS' COMPENSATION INJURY QUESTIONNAIRE

LOSS INFORMATION

Date of the injury: ____________________ Time of Injury: ____________________

Employee Name: ____________________ Date of Notification: ____________________

Where on the premises did the injury occur?

INJURY/EXPOSURE INFORMATION

Nature of Injury and Description

Body Part and Description

Cause of Injury and Description

LOSS DETAIL INFORMATION

Describe accident - sequence of events

Describe object that caused the accident

Describe all materials, used at the time

WITNESS INFORMATION

Witness(es) Name and Telephone

DATE:	Employee signature: