EMPLOYEE REPORT

PLEASE FILL OUT THIS FORM IN DETAIL. ANSWERING ALL QUESTIONS ASSURES PROMPT HANDLING OF YOUR CLAIM.

Name _____ Age _____ Phone No. _____
Address _____ Social Security No. _____
List all dependents (Full names, ages, relationship and birth dates) _____
_____ _____
_____ _____
Name of Employer _____ Name of Supervisor _____
How many hours a day do you work? _____ How many days a week? _____
What are your wages per hour? _____ Per day? _____ Per week? _____
Describe fully your physical trouble or disability _____
_____
_____
Date and hour trouble first started _____ 20____ _____ a.m./p.m.

Explain fully and exactly what happened to you, or how your physical trouble or disability first started. (You can help us give your case prompt and proper attention if you will answer this question completely. The following is an illustration of the way to answer this question: A piece of wood about two inches square was thrown a distance of six feet by a power saw, striking the outer surface of my right leg about five inches above the knee.")

_____
_____
_____
_____

(IF YOU NEED MORE SPACE, PLEASE USE REVERSE SIDE OF THIS FORM.)

Who witnessed the start of your trouble? Give names, addresses and phone numbers.

_____
If your disability was caused by another person, please give his name and address _____
_____
Give date and hour on which you first started to lose time from work _____ _____ a.m./p.m.
When were you able to return to work? _____ Are you fully recovered now? _____
If you are still having trouble, explain fully your present condition and what parts of your body are affected:

_____
_____
Date on which you first saw doctor _____
Give names and addresses of all doctors you have seen _____
_____ Are you still receiving treatment? _____
Have you had this or any other injuries at any time in the past? _____
If so, explain the nature of that trouble and approximate date it happened _____
_____
Give name and address of employer for whom you were working at time of your previous trouble _____
_____
Give name and address of doctor who saw you for previous trouble _____
_____
Dated _____ Signed _____

PLEASE SIGN THE ABOVE AND FORWARD PROMPTLY. USE OTHER SIDE OF THE FORM TO PROVIDE ADDITIONAL INFORMATION.

QUALCARE

888-342-3839

QUALCARE, INC. FIRST ACCIDENT REPORT (FAR)

Taken by: _____ Report Date to QC _____ To Employer_____ Report Time:_____ Caller : _____

Social Security # (*If available*) :

Injured EE Name: (check spelling)
Last: First:

Home Address:

DOB:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sex: ☐ M ☐ F

Person Injury Reported To:

Date of Injury: Time:

Employer/Municipality/School Board:

Location/Department:

Occupation:

Employment Status: ☐ Full-time ☐ Part-Time ☐ Seasonal ☐ Volunteer; Work Hours:_____

Witness (name & number)

Where accident occurred:

Did accident occur on premises? ☐ Yes ☐ No

City: State: Zip

Nature of Injury: (strain, contusion, laceration, etc.)

Injured Body Part:

Dominant Hand? ☐ Right ☐ Left

Accident Description: (Cause of Injury)

Has employee received medical attention? ☐ Yes ☐ No

If "yes", where?

Where is employee now?

Best way to reach employee:

Home Phone: Cell Phone: Work Phone: ext:

Was Safety Equipment Provided? ☐ Yes ☐ No

Were Safety Devices Used? ☐ Yes ☐ No

Is employee out of work? ☐ Yes ☐ No

Last date employee worked?

Date of Hire:

Salary/Wages: $_____ Number of days worked in week?_____

Shift: ☐ Days ☐ Evenings ☐ Nights

Does employee have another employer or attend school? If yes, name of employer or school:

Previous Medical Condition?

Current Medications?

Previous workers' compensation injury? Year and body part:

Primary Care Physician name and phone #:

Advised to call back for pharmacy ☐ Yes ☐ No; Advised to call NCM: ☐ Yes ☐ No

Initial Treatment PROVIDER/FACILITY: NAME/ADDRESS/PHONE:

Employment status: ☐ Was a child involved: ☐ Special Needs Child?: ☐ Yes ☐ No Age of Child:

Initial Treatment Directed by: Case Assigned to:

Supervisor Report

_____Board of Education

Please Circle: Vehicular Accident Non-Vehicular Accident Police Report Attached

Name of Injured _____ Date/Time of Injury _____

Occupation _____ Dept. _____ Date of Hire _____

Nature of Injury _____

Entity Vehicle _____ Description of Damage _____

Location of Accident _____

1. What job was employee doing including tools, machine, materials or vehicle used?

_____

_____

_____

2. How was employee injured?

_____

_____

_____

3. What improvements should be made with method, procedure or injured's performance?

_____

_____

_____

4. What was defective or in an unsafe condition?

_____

_____

_____

5. If equipment, etc., was involved, where is equipment now? Please store any involved equipment for inspection purposes.

_____

_____

_____

6. What equipment should be used?

_____

_____

_____

7. What steps were taken to prevent similar injuries?

_____

_____

_____

Supervisor's Name _____

Title: _____

Date of Report: _____