

**TEAMWORKS PROFESSIONAL SERVICES, INC.**

**Injury Report**

Client Name / Location: \_\_\_\_\_ WC Policy # \_\_\_\_\_

Employee Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Fulltime/Part-time: \_\_\_\_\_ # hour/week \_\_\_\_\_

Married: Yes \_\_\_\_\_ No \_\_\_\_\_ No. of Dependents: \_\_\_\_\_ Job Title: \_\_\_\_\_

**Accident Information:**

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ am/pm Time Employee Began Work: \_\_\_\_\_ am/pm

Date Supervisor Notified: \_\_\_\_\_ Injury Reported to: \_\_\_\_\_

Type of Injury/Illness: \_\_\_\_\_

Body Part Affected: \_\_\_\_\_ Circle One: Left Right Both Unknown

Describe Employee's Activity When Injury Occurred: \_\_\_\_\_

Provide Details of How the Injury Occurred: \_\_\_\_\_

Safeguards or Safety Equipment Provided? \_\_\_\_\_ Used? \_\_\_\_\_

Location where accident occurred: \_\_\_\_\_

Witness/Phone: \_\_\_\_\_ Witness/Phone: \_\_\_\_\_

**Medical Treatment Information:** Did employee seek medical care? Yes \_\_\_\_\_ No \_\_\_\_\_

Medical Facility used: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician name(s) and address(es): \_\_\_\_\_

**Work Status:** Did employee lose any time from work? Yes \_\_\_\_\_ No \_\_\_\_\_

Date released to work: \_\_\_\_\_ Date returned to work: \_\_\_\_\_

I certify that the above information is true to the best of my knowledge. I authorize the release to my employer of all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the company will use the information to verify my disability and determine my eligibility for appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, and clinics, insurance companies and worker's compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for work comp benefits. A photocopy of this authorization will be as valid as the original.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax to Nicole Luke at Teamworks. (801-434-9300) Please call if you have any questions or need help with the form.(801-434-8900)

Also, please fax or send in any paperwork the employee brings back from the doctor.

Date of Injury: \_\_\_\_\_ Date Supervisor Notified: \_\_\_\_\_ Date Reported to Teamworks: \_\_\_\_\_

Supervisor/Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Any concerns regarding injury? \_\_\_\_\_