

BEAVER COUNTY
EMPLOYEE'S REPORT FOR WORKER'S COMPENSATION

Employee's name: _____ Phone: _____

Address: _____
(No. and Street) (City or Town) (State) (Zip)

Social Security#: _____ - ____ - _____ Date of Birth: ____/____/_____

Male ___ Female ___ Married ___ Single ___ Number of dependent children: _____

Date of Hire: ____/____/_____ Department: _____

Job Title: _____ Normal work hours _____ per week

Exact location of injury or accident: _____

Was place of accident or exposure on employer's premises? _____

Date of injury or accident: ____/____/_____ Time of injury or accident: _____

What shift: _____ Property or equipment involved: _____
(If applicable)

What task was employee doing when injured? _____

Description of incident and injury to person involved (be specific):

Body part(s) involved:

Names of witnesses:

Attending physician: _____ Time missed:

Have you returned to work? Yes ___ No ___ If so, when?: ____/____/_____

Comments: _____

Supervisor's initials acknowledge employee's report of accident: _____ Date: _____

Employee's Signature and Date: _____

Date of report: ____/____/_____

*** Form must be completed *in full* in order for claim to be processed.**