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Montgomery, AL 36117-3502
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EMPLOYEE'S REPORT OF INJURY

Your Name:			
Address:	City:	State:	Zip:
Telephone:	Cell Phone:		
Date of Birth:	Social Security Number:		
Employer's Name:			
Employer's Address:	City:	State:	Zip:
Employer's Telephone:	Email:		
Date of Injury:	Time of Injury: AM ☐ PM ☐		
What was your occupation when you were injured?			
Were you doing your regular work when injured? YES ☐ or NO ☐			
What is the date you were hired by the above employer?			
Are you a Full-time or Part-time employee?	Are you right or left handed?		
Were you on the above employer's premises or at his plant when injured? YES ☐ or NO ☐ If no, please provide the address where you were injured:			
When did you first report your injury to your employer or supervisor?			
To whom did you report this injury?			
Describe fully what you were doing and how the injury occurred:			
Nature and Location of Injury (Describe fully and give the exact part of body, right or left, etc):			
What is your rate of pay per hour? How many hours per week do you work?	Are you allowed board, lodging or other advantages besides your wages? YES ☐ or NO ☐ If yes, please explain:		
Have you returned to work? YES ☐ or NO ☐ If yes, what date did you return to work?	Have you treated at an emergency room or hospital? YES ☐ or NO ☐ If yes, please provide the name & telephone # of the facility:		
What is the name of your current doctor?			
Who selected this physician?	Date of first doctor's visit:	Date of last doctor's visit:	
Are you still receiving treatment? YES ☐ or NO ☐	If yes, what is the date of your next appointment?		
What is the name and telephone # of your current pharmacy?			
Did someone or something other than yourself cause your injury? (Please explain)			
Names & telephone # of witnesses to this on-the-job accident:			
Have you ever filed any previous workers' compensation claims? YES ☐ or NO ☐ If yes, please provide details:			
Have you ever received medical care for the above injured body part(s)? YES ☐ or NO ☐ If yes, when:			
Do you receive any type of Social Security income? YES ☐ or NO ☐ If yes, monthly benefit:			
Do you receive Medicare benefits? YES ☐ or NO ☐ If yes, as of what date:			
Signature:	Date Completed:		