GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

# WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY (COMPLETE ALL ITEMS)

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|---|---|---|
| EMPLOYEE'S NAME: (last) (first) | | |
| EMPLOYEE'S ADDRESS: (no.) (street) | | |
| (city) (state) (zip) | | TELEPHONE: Home: _____ Work: _____ |
| SOCIAL SECURITY NO. | DATE OF BIRTH (mo) (day) (year) | SEX: ☐ Female ☐ Male |
| MARITAL STATUS: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced | | NUMBER OF DEPENDENT CHILDREN UNDER 18 AT DATE OF INJURY _____ |
| DATE OF INJURY OR ILLNESS (mo) (day) (year) | TIME: ☐ AM ☐ PM | LAST DAY WORKED: |
| NAME OF AGENCY | ADDRESS OF AGENCY | WORK COUNTY |
| REPORTED TO SUPERVISOR ☐ Yes ☐ No | NAME OF SUPERVISOR | DATE & TIME REPORTED _____ (am) (pm) _____ (mo) (day) (year) |
| IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN: | | |
| HAVE YOU SOUGHTMEDICAL ATTENTION? ☐ Yes ☐ No | NAME, ADDRESS AND PHONE NO. OF DOCTOR: | |
| ANY SICK, VACATION OR PERSONALDAYS USED FOR THIS INJURY? ☐ Yes ☐ No | NUMBER AND TYPE | |
| HAS ANY INSURANCE COMPANY PAID FOR TREATMENT AS A RESULT OF THIS INJURY? ☐ Yes ☐ No | NAME AND POLICY NO. | |
| WHAT DUTY WERE YOU PERFORMING AT TIME OF INJURY? (BE SPECIFIC) | | |
| PLACE WHERE INJURY OCCURRED (BE SPECIFIC) | | |
| DETAIL HOW INJURY OCCURRED (USE REVERSE SIDE IF NECESSARY) | | |
| DID A THIRD PARTY CAUSE OR CONTRIBUTE TO ACCIDENT? ☐ Yes ☐ No | | |
| IF YES, EXPLAIN AND PROVIDE ADDRESS AND PHONE # OF NEGLIGENT PARTY (USE REVERSE SIDE IF NECESSARY): | | |
| DESCRIBE INJURY (INDICATE PART(S) OF BODY AFFECTED) | | |
| ANY WITNESS(ES) TO INJURY ☐ Yes ☐ No | IF YES, NAME(S): | |
| HAVE YOU SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY/ILLNESS? ☐ Yes ☐ No (IF YES, IDENTIFY EACH ON REVERSE SIDE.) | | |
| DATE THIS FORM COMPLETED _____ (mo) (day) (year) | SIGNATURE OF INJURED EMPLOYEE | |
| IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE, SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM | | |



**PO Box 2934 • Clinton, IA 52733-2934 • Fax 847-621-7101**

**Reverse side must be completed if applicable before submission to Tristar**

ADDITIONAL DETAILS HOW INJURY OCCURRED:

PREVIOUS INJURIES OR ILLNESSES

| DATE(S) OF INJURY/ILLNESS | DESCRIBE INJURY/ILLNESS | WAS THIS WORKERS' COMPENSATION (YES OR NO) | NAME AND ADDRESS OF DOCTOR | IF YES, AMOUNT OF SETTLEMENT |
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ADDITIONAL DETAILS CONCERNING THIRD PARTY NEGLIGENCE



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