Employers' Incident Report

DSP COMPANY INFORMATION

Company name: _____

Address: _____

Policy number: _____

STATION INFORMATION

Station ID: _____

Station address: _____

REPORTED TO

Name of person claim reported to: _____

Phone number: _____

Email address: _____

EMPLOYEE INFORMATION

Employee name: _____

Employee's address: _____

Employee phone number: _____

Employee SSN: _____

Employee DOB: _____

Employee gender: _____

Please note that transmission and storage of this document should be done with caution. While the information is necessary for accurate reporting, personal information has been captured.

EMPLOYMENT INFORMATION

Date of hire: _____

Employment status: _____

Job title: _____

State of payroll: _____

Rate of pay: _____

Manager: _____

WITNESS DETAILS

Witness name: _____

Witness phone: _____

Witness address: _____
*obtain witness statement

INCIDENT INFORMATION

Date of loss: _____

Time of loss : _____

Time employee began work on DOL: _____

Location of Loss: _____

Incident description: _____

INJURY INFORMATION

Body part(s) injured: _____

Prior injury to this area? _____

MEDICAL TREATMENT DETAILS

Date of first treatment: _____

Provider/clinic name: _____

Provider/clinic phone number: _____

Provider/clinic address: _____

Date of next office visit: _____

Treatment plan: _____

Work status: _____