



Workers' Compensation REPORT OF INJURY FORM

FILL OUT THIS FORM IN DETAIL. ANSWER ALL QUESTIONS TO ASSURE PROMPT HANDLING OF YOUR CLAIM.

EMPLOYEE PERSONAL INFORMATION:

Full Name

Date of Birth

Address

Phone

Social Security Number

Male ☐ Female ☐

EMPLOYMENT INFORMATION:

Job Title

Name of Employer

Employer's Address

Employer's Phone Number

Date of Hire

Department

Supervisor Name

Number of Days Per Week

Number of Hours Per Day

Hourly Wage Rate or Salary

INJURY INFORMATION:

Date of Injury

Time

Date Injury Reported

Name of the Person you reported the Accident to

Exact Location of your accident (Be Specific)

Report Claim To: Cannon Cochran Management Services, Inc.

Fax: 1-217-477-5452

Email: clearspring@ccmsi.com

Toll Free: 1-844-975-3466



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Describe the accident

What part of your body was injured?

Who witnessed the accident?

MEDICAL TREATMENT INFORMATION:

Where did you first seek medical treatment?

Did you lose time from work/Date of first day missed?

Current treating Doctor Name

Phone No:

Doctor's Address

Next Appointment date

Have you made a Workers' Compensation claim or received compensation in the past?

SIGNATURE:

Employee Signature

Print Name and Phone Number

Date

Employer Signature

Print Name and Phone Number

Date

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