TRAVELERS

Workers Compensation Claim Reporting Worksheet

*** Employees must notify their supervisor of any accidents/incidents immediately.**
*** EPIC Supervisors should complete the report below (to the best of your ability) within 24 hours and submit it to sdjohnson@wvesc.org or fax to S. Johnson at 304-267-3599. [Be as detailed as possible / do an investigation / note if the employee is seeking medical attention / attach pics if applicable - you can attach additional pages if needed]**
*** If the employee seeks medical attention, documentation of that medical visit along with any follow up information including a fitness for duty should be sent to sdjohnson@wvesc.org as soon as it is obtained.**

ACCOUNT / ACCIDENT INFORMATION

PREPARER'S PHONE NUMBER	PREPARER'S TITLE	PREPARER'S NAME	EMPLOYMENT STATE

SUBSIDIARY (COMPANY) NAME	SUBSIDIARY (COMPANY) ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY (COMPANY) MAILING ADDRESS (STREET, CITY, STATE & ZIP) ☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER ☐ MALE ☐ FEMALE	PRIMARY LANGUAGE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE ☐ FULL-TIME ☐ PART-TIME ☐ OTHER	REGULAR ASSIGNED DEPARTMENT	REGULAR OCCUPATION
OCCUPATION WHEN INJURED		
EMPLOYEE'S WORK SCHEDULE REGULAR WORK HOURS _____	HOURS/DAY _____	DAYS/WEEK _____
EMPLOYEE'S WAGE INFORMATION: $_____HOUR OR $ _____/ ANNUAL OR_____/ WEEKLY OVERTIME: $_____ ADD'L BENEFITS: $_____		
DATE OF HIRE OR LENGTH OF EMPLOYMENT		

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	SUPERVISOR'S EMAIL ADDRESS:	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK OR ARE THEY WORKING MODIFIED DUTY BEYOND THE DATE OF THE INJURY? ☐ YES ☐ NO	IS THE EMPLOYEE BACK AT WORK? ☐ YES ☐ NO IF YES, DATE RETURNED TO WORK? IS THERE AN ANTICIPATED RETURN TO WORK DATE? ☐ YES ☐ NO IF YES, ANTICIPATED RETURN DATE?

RETURN TO WORK STATUS ☐ LIGHT ☐ MODIFIED ☐ REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH ☐ YES ☐ NO
DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE INJURY? ☐ YES ☐ NO	IF YES, WHAT ARE YOU QUESTIONING? ☐ INJURY WORK RELATED ☐ EXTENT OF INJURY ☐ OTHER	

WITNESS INFORMATION

NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	
NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	
NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	

INJURY INFORMATION

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, PLEASE DESCRIBE)
☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY)

☐ UNKNOWN
☐ NO MEDICAL TREATMENT
☐ FIRST AID/MINOR ON SITE TREATEMENT
☐ DOCTOR'S OFFICE/WALK-IN CLINIC
☐ EMERGENCY ROOM
☐ HOSPITAL/CLINIC – ADMITTED >24 HOURS

DESCRIPTION OF TREATMENT AND DATE OF 1st TREATMENT

NAME, ADDRESS, PHONE NUMBER OF TREATING FACILITY

PHYSICIAN NAME

INSURED CONTACT INFORMATION

CONTACT NAME	PHONE NUMBER
EMAIL ADDRESS	BEST TIME TO CONTACT AND WHERE TO CONTACT

ADDITIONAL NOTES/COMMENTS OR CUSTOMER SPECIFIC INFORMATION

TRAVELERS

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