

Worker's Comp Incident Form

Patient Name _____ Today's Date _____

Date of the Incident _____

1. Name of Compensation Carrier: _____
2. The date of the work related injury was: _____
3. The time that the injury occurred was: _____ a.m. / p.m.
4. The last date worked was: (month)_____/ (day)_____/ (year)_____
5. My current job status is: (please mark the appropriate response below)
 - off work as a result of the injuries sustained in the reported work accident
 - working full duty
 - working light duty
6. I (mark appropriate response) have have not been involved in previous work related accidents/injuries
7. This accident was: (mark appropriate response)
 - not reported to the employer reported to the employer
8. The name of the employee it was reported to was: _____
Employee's Job Title _____ Phone # _(_____)_____-_____
9. The injury occurred at (location): _____
10. How long have you been employed prior to the accident: _____
11. What type of work were you performing at time of injury: _____

12. Describe the accident: _____

13. I have (mark appropriate response):
 - been treated by another doctor for the injuries sustained in this accident
 - not been treated by another doctor for the injuries sustained in this accident

If you have been treated by another doctor, please continue with the following question.:

14. List the doctor's name and current/past treatment: _____

15. As a result of the treatment received thus far: (mark appropriate response)
 - My condition has improved
 - My condition has not improved
 - My condition has worsened since the injury despite treatment received thus far