

**ACCIDENT REPORTING FORM: TO BE COMPLETED BY EMPLOYEE,
REVIEWED AND SIGNED BY SUPERVISOR FOR ACCURACY**

1. EMPLOYEE Name (Last, First, MI)		2. Phone Number	3. Social Security Number
4. Home Address (No & Street, City, State Zip Code)		5. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	6. Number of Dependents
7. Date of Hire (MM/DD/YY):	8. Date of Birth (MM/DD/YY):	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Hourly Wage \$
11. Hours Worked Per Day <input type="checkbox"/> FT <input type="checkbox"/> PT	12. Days Worked Per Week	13. Average 52-Week \$ _____ <input type="checkbox"/> Estimated <input type="checkbox"/> Actual	
14. EMPLOYER Address (No & Street, City/State/Zip)		15. Employer Telephone	16. Department Employee Works:
17. Employer Name/Insurance Carrier: Name and Address of Branch Responsible for This Case (Not Local Agent or Adjuster) c/o FutureComp, 711 E. Main St, Suite 201, Chicopee, MA 01020			

18. Date of Injury MM/DD/YY:	19. Time of Injury _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	20.. Source of Injury (e.g., Machine, Tool, Substance, etc.)	
21. Address/Building/School Name where Injury Occurred		22. On Employer's Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No Where? i.e. stairway, parking lot, classroom, curb, street	
23. Hospital Name/Treating Doctor Name and Address		24. Regular Occupation	25. Regular Occupation when Injured? <input type="checkbox"/> Yes <input type="checkbox"/> No
26. Name of Supervisor to Whom Was Injury Reported:		27. Date Reported (MM/DD/YY):	
28. DESCRIBE IN DETAIL How Injury Occurred (<i>I was walking down stairs and.....</i>)			
29. Injured Body Part(s) Left Arm, Right Leg, Back and Hip		30. Nature of Injury(ies) (Burn, Fracture, Fall, Cut, Strain)	
31. Witnesses to the Accident			

SIGNATURES

32. EMPLOYEE'S Name/Title	33. Employee's Signature and Date (MM/DD/YY): _____ _____
34. SUPERVISOR'S Name/Title:	35. Supervisor's Signature and Date (MM/DD/YY): _____ I have Reviewed This Form for Accuracy
36. PREPARER'S Name/Title (if Employee is unable to complete and if so, provide reason)	37. Preparer's Signature and Date _____

EMPLOYEE RETURN TO WORK

Date Employee Returned to Work (MM/DD/YY)	Returned to Regular Occupation <input type="checkbox"/> Yes <input type="checkbox"/> No
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