Employee Accident/Injury Report/Internal Form

OFFICE USE ONLY	
	ID#
	Dept. #
	Months
	Calendar
	Building #

☐ ***Check when employee has been given a copy of the Employee Work Comp Information Sheet.***

Outside medical attention: Immediately fax this completed form to (816) 521-5677 and call the ISD Employee Work Comp Office at (816) 521-5424. Send this form and the Treatment Authorization form with the Employee to ISD Employee Health Clinic (or Treatment Authorization form only to Urgent Care of Kansas City, Truman Medical Center ER or Centerpoint ER).

First aid or no medical attention: Fax this form to (816) 521-5677 and call the ISD Employee Work Comp Office at (816) 521-5424.

EMPLOYEE INFORMATION

Employee ID#:_____ Full Name: _____

Phone: (Home #) _____ (Work #)_____ Primary Work/Building Site: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: M / S / Sep / D / W Gender (M/F)_____

Job Title: _____ Work Status: (Full/Part Time/Sub)_____

ACCIDENT/INJURY INFORMATION

Time Employee Began Work: _____ AM/PM Date of Injury:_____

Time of Injury: _____ _____ Check If Time Cannot Be Determined

Date Employer Notified: _____ Time Notified: _____ Who Was Notified _____

Description of What Happened: _____

_____

Cause of Injury: _____

Body Part(s) Injured: (Left/Right) _____ Type of Injury: _____

Witnesses: _____

Did Injury Occur on Employer Premises: Y/N _____ Inside _____ Outside _____ Vehicle_____

Injury Location Site: _____ Location at Site: _____

TREATMENT INFORMATION

Is Employee Going to Receive Medical Attention: Y/N_____ On-Site First Aid: Y/N_____

ISD Employee Health Clinic: ___ **(7AM – 12:00 Noon & 1PM – 6 PM, M-F; 8AM – 12 Noon, Sat)**

The Urgency Room: ___ (8 AM – 8 PM, 7 Days/Weekly)

Urgent Care of Kansas City: ___ (8:30 AM – 9 PM, M-F; 8:30 AM – 6 PM Sat; 8:30 AM – 5:30 PM, Sun; 8:30 AM – 3:30 PM, Holidays)

___ Other Provider Care Site_____

Emergency Care: ___Truman Medical Center Lakewood; ___Centerpoint; ___ Other_____

Employee Signature: _____ Date: _____

Supervisor/Nurse Signature: _____ Date:_____

OFFICE USE ONLY

Report #: _____ **SSN#:** _____ **Wage:** _____

Hire Date: _____ **Entered:** _____ **PMA Management Corp. #0839910**

Phone: 1-888-476-2669