Please complete this form and return it to Central Office.

EMPLOYEE'S REPORT OF INJURY

Date: ____________________

Full name of insured employee ____________________

Address ____________________ Home Phone No. ____________________

Sex ______ Age ____ Married or Single __________ Department _______ Badge No. ______________

If you have dependent children under 21 years of age living with you complete the following:

Name of Dependent Child	Age	Name of Dependent Child	Age

Which of the above dependent children were not at least 50% supported by you? ____________________

____

Employer's name ____________________

Occupation when injured ____________________ Name of Foreman ____________________

Were you doing your regular work? ____________________ If not, what work ____________________

Exact place where injury occurred ____________________

Date of Injury ____________________ Hour of Day (a.m./p.m.) ____________________

Witnesses' Names ____________________

Describe fully how injury happened ____________________

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____________________ Continue on back if necessary

What part of your head, limbs or body was hurt? ____________________

Describe your symptoms ____________________

Attending Physician's name and address ____________________

Number of treatments to date ____________________

Names and addresses of any other doctors seen ____________________

Are you still receiving treatment? ____________________ From whom? ____________________

Did you lose time from work? ____________________ If so, what was your last day worked? ____________

If you have returned to work, what was the date? ____________________

If you have not yet returned to work, when do you expect to return? ____________________

To whom was injury reported? ____________________ On what date: ______________ Time: __________

Please sign your name ____________________ Date signed: ____________________

If medical attention is necessary, your employer will furnish treatment subject to the provision of the Workman's Compensation Act.