

WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ. 85005-9070
Do not attach form to email; mail in envelope to address above or FAX to 602-542-3373.

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.ica.state.az.us

ANSWER ALL QUESTIONS FULLY (Use the back of this form to indicate any further information.)

1. NAME OF INJURED WORKER: _____
LAST FIRST M.I.

SOCIAL SECURITY # *: _____ BIRTH DATE: _____ PHONE #: () _____

2. ADDRESS: _____
CITY STATE ZIP CODE

3. MARITAL STATUS: SINGLE MARRIED DIVORCED DEPENDENTS AT TIME OF INJURY: YES NO

4. EMPLOYER'S FULL NAME: _____ PHONE #: _____

5. ADDRESS: _____
CITY STATE ZIP CODE

6. DATE HIRED: _____ WHERE HIRED: _____ OCCUPATION: _____

7. HOURS WORKED PER DAY: _____ PER WEEK: _____ HOURLY WAGE: _____

8. DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE? YES NO

9. DATE OF INJURY (MO/DAY/YEAR): _____ TIME OF INJURY: _____ AM PM

10. ADDRESS OR LOCATION OF ACCIDENT: _____

11. DID YOU STOP WORK IMMEDIATELY? _____ WHEN DID YOU STOP? _____

12. WHEN DID YOU REPORT THE INJURY? _____ TO WHOM? _____ TITLE: _____

13. WHEN DID YOU RETURN TO WORK? _____ REGULAR WORK _____ OTHER WORK _____

14. NAMES OF PERSONS WHO SAW THE ACCIDENT.

1. NAME: _____ ADDRESS: _____ PHONE #: _____

2. NAME: _____ ADDRESS: _____ PHONE #: _____

15. WAS ACCIDENT CAUSED BY ANOTHER PERSON? _____ IF SO, BY WHOM? _____

16. NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT: _____

17. STATE HOW ACCIDENT HAPPENED: _____

18. BODY PART INJURED: _____ DESCRIBE THE INJURY (CUT, BRUISE, ETC.): _____

19. WHERE WERE YOU FIRST TREATED: NAME: _____ ADDRESS: _____

20. WHO TREATED YOU FOR THIS INJURY: NAME: _____ ADDRESS: _____

21. OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS? YES NO

NAME OF STATE WHERE ACCIDENT HAPPENED: _____ WORK INJURY: YES NO

22. OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY? YES NO

DATE OF INJURY: _____ WORK INJURY: YES NO

NAME OF STATE WHERE ACCIDENT HAPPENED: _____

23. OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS? YES NO

IF SO, FROM WHOM? _____ AMOUNT? _____ WHY? _____

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

Signature of injured worker or injured worker's authorized representative is REQUIRED.

Date

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.