(if applicable)

Time of Accident (if applicable)

Place where accident occurred (if applicable)

What is the nature of the injury or occupational disease?

List any body parts involved:

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

[redacted]

date and time)?	Has the employee ___ YES returned to work? ___ NO	If yes, when (date and time)?
m?	Name and address of treating physician, if applicable or known	

Was anyone else involved? YES NO

Names of others involved

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisors Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the 6 W D W H R I Consumer Health U Assistance Toll Free 1-888-333-1597 Web site W