Chubb Workers Compensation
Report of Injury Worksheet

ACCIDENT LOC (STREET ADDRESS): CITY: STATE:

COUNTY: STATE: ZIP: ON PREMISE (Y/N):

INJURY/DISEASE (I/D): TIME OF INJURY: TIME SHIFT BEGINS: A/P: ENDS: A/P:

SUPERVISOR TIME REPORTED: A/P: LAST WORKED:

TIME LEFT: A/P: LOST TIME (Y/N): FIRST OFF: # OF EMPLOYEES INJURED:

FATAL (Y/N): DATE OF DEATH: WHAT WAS THE EMPLOYEE DOING?

NATURE OF INJURY/BODY PART: OBJECT/SUBSTANCE INVOLVED:

HOW COULD EMPLOYER PREVENT?

HOW COULD EMPLOYEE PREVENT?

WHO CAUSED THE ACCIDENT IF NOT THE EMPLOYEE?

ADDRESS OF THE PERSON WHO CAUSED THE ACCIDENT:

RETURNED (Y/N): DATE: TIME: AP REG ( ) LIGHT ( ) DUTY (X) RETURN WAGE:

RETURN OCCUPATION: PAID WHILE INJURED? (Y/N):

REASON TO DOUBT VALIDITY OF CLAIM?

WITNESS NAME(S): ADDRESS CITY STATE ZIP

DOCTOR'S NAME: ADDRESS CITY STATE ZIP

DOCTOR'S PHONE #: HOSPITALIZED (Y/N)?

HOSPITAL NAME: ADDRESS CITY STATE ZIP

HOSPITAL PHONE #: TOTAL DEPEND. #: MINOR DEPEND. #:

DEATH–IF YES, NEXT OF KIN NAME & ADDRESS:

PREPARER'S PHONE NUMBER: MAILING INSTRUCTIONS:

THE ADDRESS THE EMPLOYER WOULD LIKE THE FIRST REPORT OF INJURY MAILED TO:

ADDITIONAL ADDRESS EMPLOYER WOULD LIKE THE FIRST REPORT OF INJURY MAILED TO:

YOUR CLAIM # _____