Employee Accident Report Form

TO BE COMPLETED BY INJURED EMPLOYEE IMMEDIATELY

Fax to Surge (603)624-7007 after every accident – Injury Contacts: Tina Bell or Jay Printzlau (603) 623-0007

CLIENT INFORMATION

*Client Company Name: _____ Client #: _____

*Supervisor Name: _____ *Supervisor Telephone #: _____

EMPLOYEE INFORMATION

*Injured Employee's Name: _____ *DOB: _____

*Telephone Number: _____ *Social Security Number: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

Date of Hire: _____ *Job Title: _____ *Job at Time of Injury: _____

Marital Status: ____Single ____Married Number of Dependents: _____ Height: _____ / Weight: _____

Smoker: ____ Yes ____ No Prior/Chronic Health Issues: _____

_____

INJURY INFORMATION

*Injury Date: _____ Injury Time: _____ Started Work Time: _____

Type of Injury: _____ *Body Part Injured: _____

*Street Address & Town of Accident: _____

*Full Accident Description (How did it occur): _____

_____

_____

_____

Was any safety equipment used?: ____Yes ____No If Yes, describe:_____

_____

Have you had prior injuries?: ____Yes ____No if Yes, describe: _____

_____

Witness(es) Name(s) & Telephone Number(s): _____

_____

_____

TREATMENT INFORMATION

Medical Treatment (check one): _____None _____Hospital _____Walk-In Clinic _____MD Office

Name, Address, and Phone Numbers of all care provider(s): _____

_____

_____

_____

_____

_____

_____

Are you missing work?: _____ Yes _____No *If Yes, date missing work began? _____

If Yes, date you expect to return to work? _____

BRIEFLY DESCRIBE your job duties: _____

_____

_____

_____

_____

***** EMPLOYEE SIGNED AUTHORIZATION *****

Name (Please Print): _____ Date of Injury: _____

I hereby authorize **SURGE RESOURCES** (or any of its representatives), to be furnished any information and facts regarding this injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability, recommendations for further treatment and provider fees for service. **This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient's workers' compensation claim for the date of injury stated above, including any past history of complaints of, or treatment of, a condition similar to this claim.** This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above noted date of injury and for no other purpose, now or in the future.

Additionally, I hereby authorize **SURGE RESOURCES** (or any of its representatives), to speak with:
Designee's Name: _____ regarding any and all information related to this work injury. My relationship to the above authorized designee is: _____. I understand this authorization will remain in effect until I revoke such authorization in writing and agree that a photographic copy of this authorization shall be as valid as the original.

Employee Signature: _____ Date: _____