Claims Administrative Services, Inc.

Our reputation for excellence is no accident.®

Employee's Injury Report

This form must be completed in detail and signed by the injured employee.

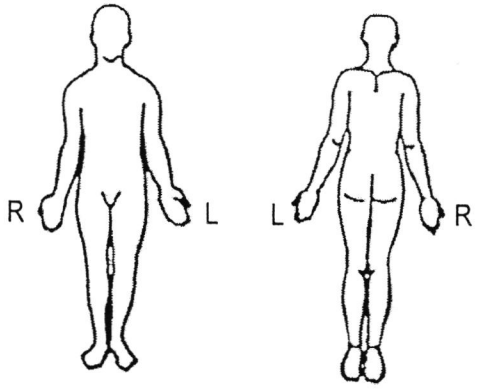
Your Full Name		
Employer		Location of Accident
Social Security Number (Last 4 digits only) XXXX-XX-	Date of Birth	Department You Work For
Your Address (Street, City, State, County, Zip)		Supervisor's Name
Phone Number Where You Can be Reached		Job Title at Time of Injury
Date of Hire		How Long in Current Position Yrs. Mos.

Details of the Injury

Date of Injury	Time of Injury AM / PM	Date you first Lost Time
Where in the workplace did your injury occur?		
Describe in detail how your injury occurred.		
What safety equipment were you using at the time of the accident?		
What can be done to prevent this type of injury in the future?		

When were you first aware of this injury?	
When did you first notify your supervisor of your injury?	
What part of your body is injured?	Describe the injury.

On the diagram provided below, please circle the part(s) of your body where you are experiencing pain due to this injury.



Did anyone witness your accident? List the names of any witnesses.
Was anyone else injured in this accident? List the names of any other injured people.
In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.

I certify that the information contained in this report is true and correct.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.

I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.

Employee's Printed Name	Employee's Signature	Date

I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence this date.

Witness Printed Name	Witness Signature	Date

Supervisor Printed Name	Supervisor Signature	Date