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| --- |
| ***EMPLOYEE INFORMATION*** |
| Employee Name (First & Last) | Gender | Hired Date | Hired in NH |
|  |  |  |  |
| ID Type - Employee ID | Date of Birth | Age | Occupation when Injured |
|  **-** |  |  |  |
| Employee Address | Telephone | Wages per Hour | Hrs per Day | Days per Week | Average Weekly Earnings |
|  |  |  |  |  |  |

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| ***INJURY INFORMATION*** |
| Injury Date / Time | Date Employer Notified of Injury | Location/Jobsite & Business Name where accident occurred |
|  |  |  |
| Disability Began | Claim Type Code |  |
|  |  |  |
| Accident Description |
|  |
| Body part Injured | Cause of Injury |
|  |  |
| Nature of Injury | Witness Name | Witness Phone |
|  |  |  |
| Returned to work?  | If so, what date? | If so, at what occupation? | If so, at what duty status? |
|  |  |  |  |
| Initial Treatment | Initial Treatment Date |
|  |  |
| Name of Treating Physician | Name of Treating Hospital | Has injured died? If so, what date |
|  |  |  |

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| ***EMPLOYER INFORMATION*** |
| Employer Name | Employer FEIN | Industry Code |
|  |  |  |
| Employer Contact Name | Contact Phone Number | Employer Business Address |
|  |  |  |
| Managed Care Organization |  |
|  |  |
| Leased Employee? Client Company | OCIP/Wrap-Up Policy? Name of policy holder |
|  |  |

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| ***INSURER INFORMATION*** |
| Insurance Carrier | Insurer Type | Policy Number | Telephone Number |
|  |  |  |  |

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| ***SUBMITTER INFORMATION*** |
| Submitter Name | Title of Submitter | Represents  | Telephone Number |
|  |  |  |  |