# Accident Report

## Worker's Compensation

For report only: ______ Yes ______ No

**VSC District, Project Name, and Job #:**

**Date of Report:** ___________________________________

**Name & Phone # of Employee Reporting accident:**

## Accident Information:

| **Date of Accident:** | **Time of Accident:** __________________ ☐ AM ☐ PM |
|---|---|

**Address where accident occurred:**

**Please give a description of the accident:**

**Were authorities contacted? (police, fire, ambulance)** **If yes, who:** _______________________________________

☐ Yes ☐ No

**Was a report # given?** **If yes, list number:** _______________________________

☐ Yes ☐ No

**If any safeguards provided, please describe:**

**In the event of a fatality, what is your OSHA #?**

## Claimant Information:

**Name and Address of Injured Employee:**

| **City:** | **State:** **Zip:** |
|---|---|
| **Home Telephone #:** | **Alternate Telephone #:** |
| **Date of Birth:** | **Last 4 of Social Security #:** |
| **Marital Status:** ☐ Single ☐ Divorced ☐ Married ☐ Widowed | **How many dependents?** |

**Covered by other insurance?** ☐ **Yes** ☐ **No** **If yes, company name:**

**Occupation performed at time of accident:**

**If fatality, what date did it occur?**

**Signature of Employee Completing Report:** **Date:**

**For workers compensation claims, please mail all medical bills and accompanying medical records to:**

**Gallagher Bassett Services, Inc., P. O. Box 2831, Clinton, IA 52733-2831**

## Employment Information

Employment status (check one):
□ Full-time □ Part-time □ Temporary □ Contract
□ On-Call □ Seasonal □ Retired □ Volunteer

Date of hire:
Hours worked per day:
Days worked per week:

Supervisor's Name & Telephone #:

Was there lost time? □ Yes □ No
Eligible for salary continuation? □ Yes □ No
Last day worked: ___________________________________
Hourly or weekly wage: $ ____________ □ Hourly □ Weekly
Weeks worked in last 12 months: ______________________

Paid thru date: _____________________________________
Date disability began: _______________________________
Date returned to work or expected to: _________________
Wage listed? □ Actual □ Estimate
Date employer notified of injury: ______________________

## Injury Information

Were any injuries incurred? □ Yes □ No

What part of the body? ______________________________

Give a description of the injuries:

What treatment was given? (please check)
□ Minor on-site remedies
□ Emergency evaluation

□ No medical treatment
□ Minor clinic or hospital
□ Inpatient Hospitalization

Name, Address & Telephone # of Treating Physician:

Name, Address & Telephone # of Treating Hospital/Clinic:

## Witness Information:

Names, Addresses & Telephone #s of all witnesses to the accident:

Anything related to the accident you would like to add:

Signature of Employee Completing Report: Date:

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