MEDICAL INFORMATION (*Please type or print clearly)*

Medical Facility Visited: _____ Phone:_

Address:_____ City:_____ Zip:_____

Doctor's Name: _____

Did doctor release injured worker to return to work? Yes No

Accident investigation is critical for identifying the accident causes so they may be corrected. Please answer the following as completely as possible.

Date State WC Claim Form was provided to employee:_____ Time:_____ Location:_____

Supervisor's Name (print):_____ Ext._____ Campus:_____

Supervisor's Signature:_____ Date:_____

The information provided on this form is an accurate description of the accident/injury circumstances.

Injured Employee's Signature:_____ Date:_____