

EMPLOYEE STATEMENT OF INJURY FOR WORKER'S COMP COVERAGE

Name _____ D/O/B _____ Daytime Phone # _____

Home Address _____ City/State _____ Zip _____

Work Location and Address _____

Date of Hire _____ Job Title _____ Hr. per Wk _____ Gender _____

1. Date of Injury _____ Time: _____ SS# _____

2. Did this injury occur while you were performing your regular duties: Yes No
If no, what were you doing _____

3. Location where injury occurred _____

4. Describe **exactly** how injury occurred _____

5. Was there any equipment involved: Yes No If yes, what equipment? _____

6. Describe the body part injured **and** mark the illustration on the separate page below _____

7. Describe your symptoms (i.e., pain right knee, etc) _____

8. Did you report the injury when it occurred: Yes No
If yes, who and when did you report your injury to _____
If no, explain why it was not reported _____

9. Witnesses to the incident _____

10. Have you ever experienced the symptoms described in # 7 Yes No

A. Describe the cause of your symptoms then _____

B. Who treated you then Hospital Name _____
 Doctor's Name _____
 Date _____

This statement is true and accurate to the best of my knowledge. _____
Signature of Employee _____ Date _____

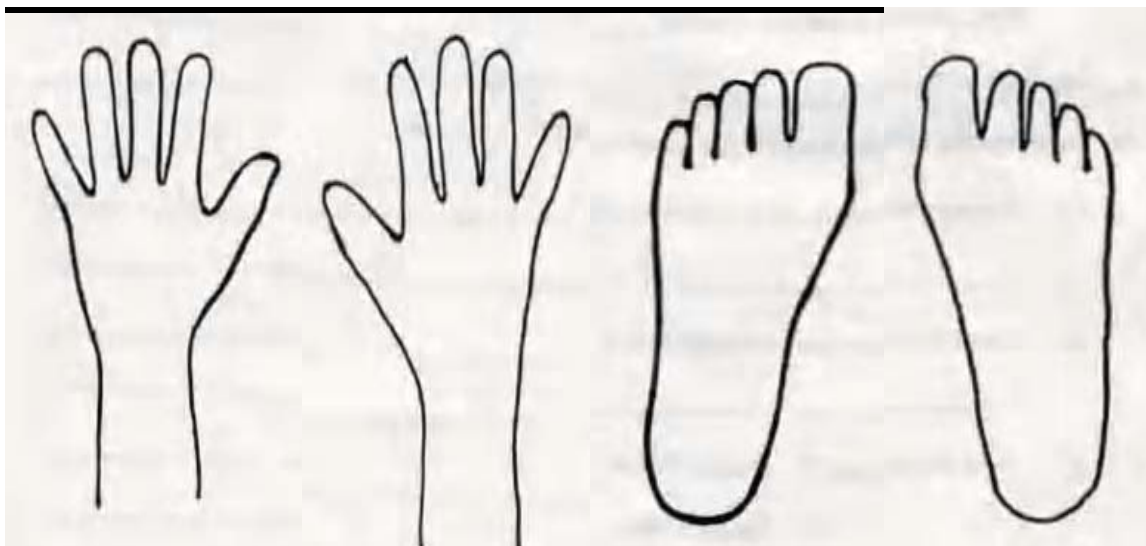
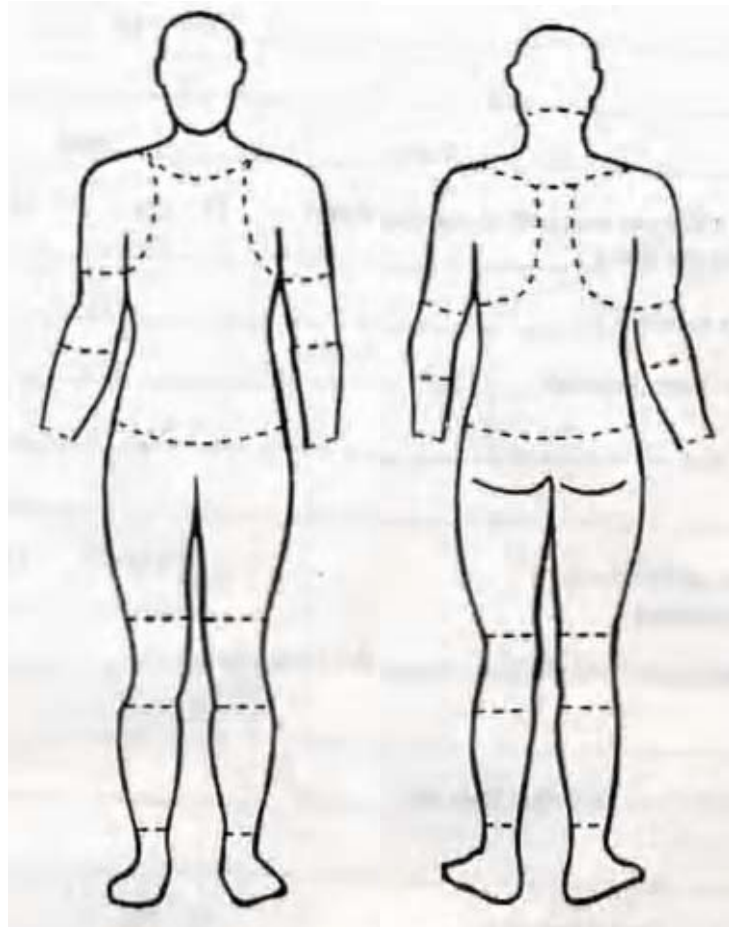
MEDICAL AUTHORIZATION FORM

I AUTHORIZE any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer that has any information as to the diagnosis, treatment or prognosis of any physical or mental condition of me, and any information regarding my occupation and salary, to give any and all such information to Community of Christ, or its representative. This authorization is to include speaking with above-named parties. A photographic copy of this authorization shall be valid as the original.

Signature (Employee) _____ Date _____

Address _____

MARK **THE AREA ON THE ILLUSTRATION BELOW** WHERE YOU ARE **HAVING THE SYMPTOMS YOU DESCRIBED IN ITEM 6 ON THE REVERSE SIDE**



___ PALM SIDE
___ BACK SIDE

___ TOP OF FOOT
___ BOTTOM OF FOOT