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

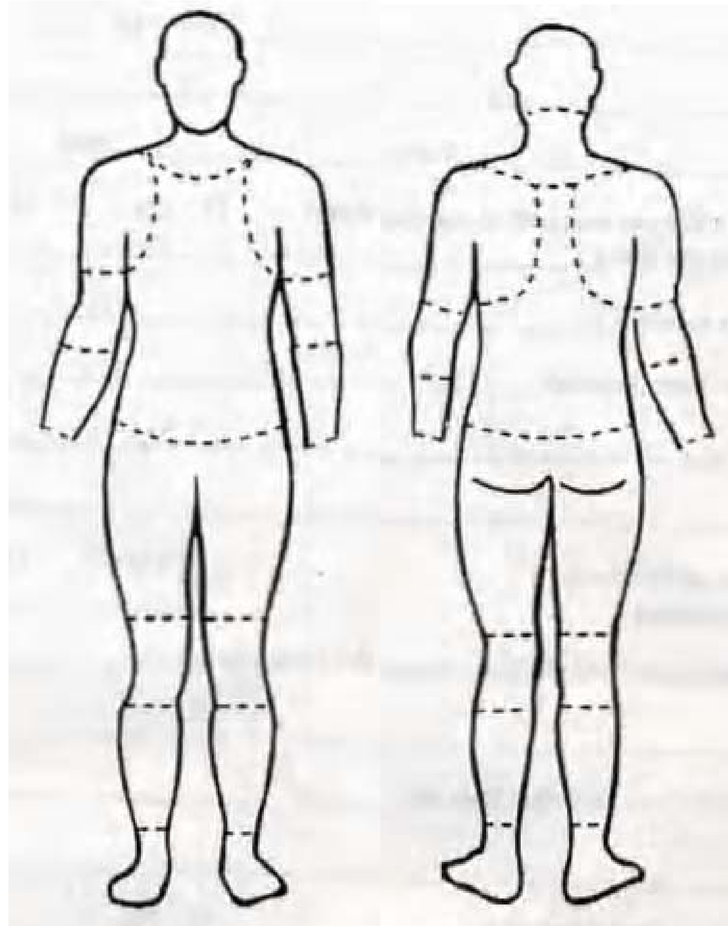
MEDICAL AUTHORIZATION FORM

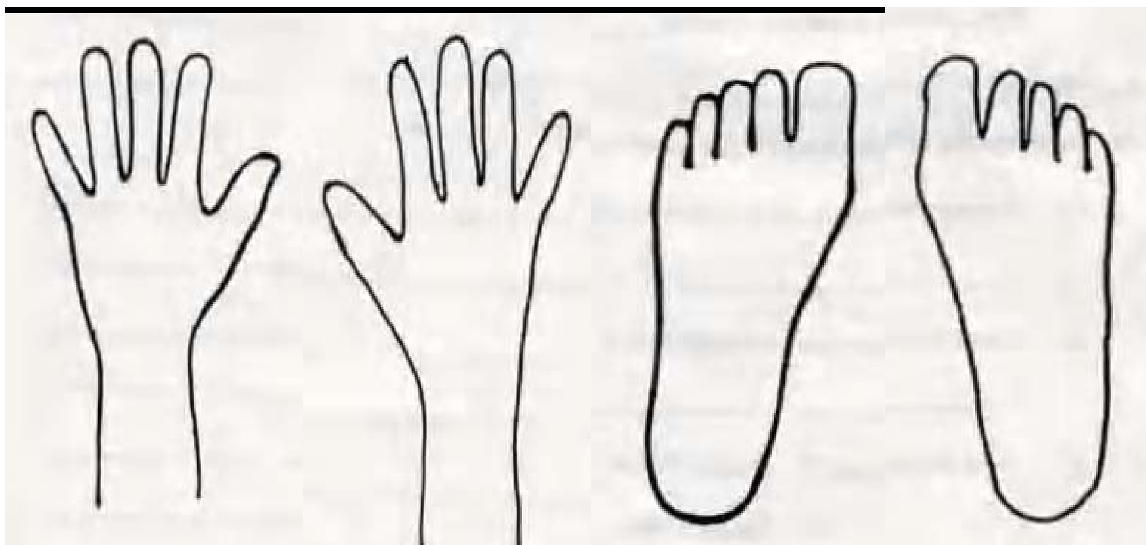
I AUTHORIZE any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer that has any information as to the diagnosis, treatment or prognosis of 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
<u>HAVING THE SYMPTOMS YOU DESCRIBED IN ITEM 6 ON THE REVERSE SIDE</u>





__PALM SIDE
__BACK SIDE

___TOP OF FOOT
___BOTTOM OF FOOT