T2 INSURANCE SOLUTIONS LLC

YOUR WORKERS COMPENSATION SOURCE

Accident Report

Branch Office:_____ Client Location:_____

Completed by Employee

Name:_____ Telephone number:_____
Address:_____
State, City, ZIP:_____
Date of birth: _____ Date of injury:_____
Day of the week:_____ Time of injury:_____ AM PM
Date reported to supervisor:_____ Name of supervisor:_____
Area where injury occurred:_____
Job performing when injured:_____
Part(s) of body affected:_____
Description of injury:_____
_____
_____
Corrective measures:_____
_____
_____

Employee Signature:_____ Date:_____

Completed by Manager

First day unable to work:_____ Was employee paid for this day:_____
Is modified duty an option:_____ If "no" then why:_____
Probable length of disability:_____
Part time or full-time worker:_____ Wage rate:_____
Name of physician:_____ Telephone number:_____
Workers compensation code:_____ Occupation when injured:_____
Was this the regular occupation:_____ If "no" what was:_____
Was PPE provided:_____ If "no" then why:_____
Names of witnesses:_____
_____
Corrective measures:_____
_____
_____

Manager Signature:_____ Date:_____