



CIRMAcare Injury Reporting Hotline

1-800-652-4762 (24 hours)

REVISED 03/24/04

LOSS INFORMATION

Loss Date: _____ Loss Time: _____ Call Type: Claim Occurrence
Caller's First & Last Name: _____ Caller's Telephone Number: _____
Injured Employee's Employment Status: Full Time Part Time Volunteer Other
Loss Location Name: _____
Loss Location Address: _____ City & State: _____ Zip Code: _____

INJURED EMPLOYEE'S INFORMATION

Employee's First & Last Name: _____
Employee's Home Address: _____ City & State: _____ Zip Code: _____
Employee's Social Security Number: _____
Employee's Telephone Numbers Work: _____ Home: _____
Gender: Male Female Date of Birth: _____ Job Title: _____
Department: _____
Supervisor's Name: _____ Telephone Number: _____
Employee's Hire Date: _____
Did employee miss work beyond normal shift? Yes No If yes, continue below
Last Day Worked: _____ Disability Date: _____ Returned to Work: _____
Time Employee Began Work: _____ Date Employer Notified: _____
Loss Description: _____
Injury Type: _____ Cause of Injury: _____ Body Parts Involved: _____
Contact Name: _____ Telephone Number: _____

TREATMENT INFORMATION (If Known)

Name of Physician: _____ Physician's Telephone Number: _____
Name of Hospital: _____ Hospital Telephone Number: _____

WITNESS

Name: _____ Address: _____
City & State: _____ Zip Code: _____ Telephone Number: _____

CLAIM NUMBER: _____