CIRMA Injury Reporting Worksheet

Keep this worksheet for your own records – do not submit to CIRMA.

Event Date/Time

Incident Date: _____ Incident Time: _____ Employer Notified: _____

Reporter and Location Information

Reported By: _____ Title: _____ Phone: _____

Location Code: _____ Location Name: _____ Address: _____

Claimant Information

Claimant Name: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Home Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____ Date of Birth: _____ Gender: ☒ Male ☐ Female

Marital Status: Select Status From List

Job Title: _____ Work Status: Select Status From List

Claimant's Supervisor: _____ Title: _____ Phone: _____

Incident Information

Description of Injury: _____

_____

Cause: Select Cause From List Body Part: Select Body Part From List

Nature Code: Select Nature Code From List

Medical Provider: *(if known)* _____ Name of Doctor: *(if known)* _____

Medical Provide Address: _____

Witness Information (if any): _____

Lost time from work: *(if known)* _____ Return to work date: _____

Lost Location Entity: _____

Address: _____

Contact Person: _____ Phone: _____ Email: _____

Additional Information

Job Classification Code: _____

Time the employee began work on the day of the injury: _____

Supervisor Notice Date: _____ Claim Incident Number: _____