



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: _____

Job Title: _____ Work Status: _____

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

Incident Information

Description of Injury: _____

Cause: _____ Body Part: _____

Nature Code: _____

Medical Provider: _____ Name of Doctor: _____

Medical Provider Address: _____

Witness Information (if any): _____

Lost time from work: _____ 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: _____

