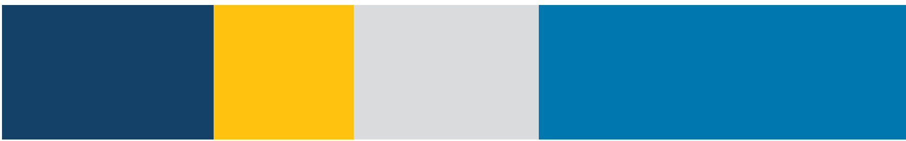
CIRMA Injury Reporting Worksheet



*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: ______________________________

Job Title: ____ Work Status: _________________________

Claimant's Supervisor: _______________________ Title: _____________________ Phone: _________________

Incident Information

Description of Injury: ____

____

Cause: ____ Body Part: ______________________________

Nature Code: ____

Medical Provider: ___________________________________ Name of Doctor: ______________________________
(if known) *(if known)*

Medical Provider Address: ____

Witness Information (if any): ____

Lost time from work: ________________________________ Return to work date: _________________________
(if known)

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: ______________________

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