Claims Management of Missouri, LLC

EMPLOYEE
Incident/Injury Report

NAME	DATE OF INCIDENT	DATE OF REPORT
ADDRESS	JOB PERFORMED	
CITY/STATE/ZIP	EMPLOYER *(IF NOT AN EMPLOYEE)*	
PHONE NUMBER	PERSON INJURY REPORTED TO	
TIME OF INCIDENT ☐ A.M. ☐ P.M.	SOCIAL SECURITY NUMBER	
LOCATION OF INCIDENT		
DESCRIPTION OF INJURY *(WHAT HAPPENED) – USE SEPARATE SHEET IF NEEDED*		

DO YOU KNOW OF ANY WITNESSES? ☐ YES ☐ NO	DO YOU KNOW OF ANY OTHER SIMILAR INJURIES? ☐ YES ☐ NO
IF YES, LIST NAMES	HOW DO YOU THINK THE INCIDENT OCCURRED *(UNSAFE CONDITION OR ACT?)*

HOW DO YOU THINK THIS INCIDENT COULD HAVE BEEN PREVENTED?
PRINT NAME OF PERSON COMPLETING THIS REPORT

SIGNATURE OF PERSON COMPLETING THIS REPORT	CURRENT DATE

Fax or mail or e-mail completed form to:

MMMA-Claims Management of Missouri, LLC
16100 Chesterfield Pkwy. W., Ste. 210
Chesterfield, MO 63017-4817

Fax: (636) 537-1362
E-mail: claims@mmm-a.com