Claims | Claims Management of Missouri, LLC | Mgmt of MO

Employee Incident/Injury Report Work Comp

<table>
<tr><td colspan="2">NAME</td><td>DATE of INCIDENT</td><td>DATE of REPORT</td></tr>
<tr><td colspan="2">DEPARTMENT</td><td colspan="2">JOB TITLE</td></tr>
<tr><td>HIRE DATE</td><td>LENGTH OF TIME ON CURRENT JOB</td><td colspan="2">SHIFT ON DAY OF INCIDENT & START TIME</td></tr>
<tr><td colspan="2">TIME of INCIDENT
AM PM</td><td colspan="2">TIME REPORTED
AM PM</td></tr>
<tr><td colspan="4">INJURY REPORTED TO & THEIR TITLE</td></tr>
<tr><td colspan="4">TYPE OF INCIDENT/INJURY
MILD MODERATE SEVERE</td></tr>
<tr><td colspan="4">LOCATION/ADDRESS OF THE INCIDENT (INCLUDE CITY/STATE/ZIP)</td></tr>
<tr><td colspan="4">DESCRIPTION OF INCIDENT/ACCIDENT--WHAT HAPPENED</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2">WERE THERE WITNESSES?
YES NO</td><td colspan="2">WERE THERE INJURIES?
YES NO</td></tr>
<tr><td colspan="2">IF YES, LIST NAMES</td><td colspan="2">IF YES, DESCRIBE INJURIES & LOCATION ON BODY</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2">FOR VEHICLE ACCIDENTS ONLY: IF YOU WERE THE DRIVER, WERE YOU WEARING YOUR SEAT BELT? YES NO</td><td colspan="2">FOR SAFETY / ALCOHOL / DRUG VIOLATIONS: Written up?</td></tr>
<tr><td colspan="2">FOR VEHICLE ACCIDENTS ONLY: IF YOU WERE A PASSENGERS, WERE YOU WEARING YOUR SEAT BELT?
YES NO</td><td colspan="2">FOR VEHICLE ACCIDENTS ONLY: IF YOU HAD PASSENGERS, WERE THEY WEARING THEIR SEAT BELT? YES NO N/A</td></tr>
<tr><td colspan="2">REFERRED FOR MEDICAL TREATMENT?
YES NO</td><td colspan="2">WHERE?</td></tr>
<tr><td colspan="3">DID INJURY RESULT IN LOSS OF TIME AT WORK?
YES NO</td><td>HOW MUCH TIME LOST?</td></tr>
<tr><td colspan="4">HOW / WHY DO YOU THINK THE INCIDENT OCCURRED (UNSAFE CONDITIONS OR ACT)?</td></tr>
</table>

DO YOU KNOW OF ANY OTHER SIMILAR INCIDENTS OCCURRING IN THE PAST? YES NO	
HOW DO YOU THINK THIS INJURY COULD HAVE BEEN PREVENTED?	
PERMANENT CORRECTIVE ACTION, RECOMMENDED TO PREVENT RECURRENCE	
HAVE YOU INJURED THIS BODY PART BEFORE? IF YES, PLEASE PROVIDE DETAILS	
ADDITIONAL COMMENTS	
PRINT NAME OF PERSON COMPLETING THIS FORM	
SIGNATURE OF PERSON COMPLETING THIS FORM	DATE
PRINT NAME OF SUPERVISOR RECEIVING FORM FROM INJURED WORKER:	
SIGNATURE OF SUPERVISOR	**DATE:**