

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 <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		SOCIAL SECURITY NUMBER AND DATE OF BIRTH	
LOCATION OF INCIDENT			
DESCRIPTION OF INJURY (WHAT HAPPENED) – USE SEPARATE SHEET IF NEEDED			
DO YOU KNOW OF ANY WITNESSES? <input type="checkbox"/> Yes <input type="checkbox"/> No		DO YOU KNOW OF ANY OTHER SIMILAR INJURIES? <input type="checkbox"/> Yes <input type="checkbox"/> 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 15450 South Outer 40 Road, Ste. 200 Chesterfield, MO 63017-4817 Fax: (636) 537-1362 E-mail: adjusters@mmm-a.com	