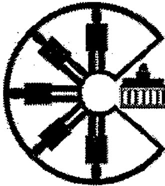

CIRMAcare Injury Reporting Hotline

1-800-652-4762 (24 hours)

REVISED **03/24/04**

LOSS INFORMATION

Loss Date: ____________ Loss Time: ____________ Call Type: Claim ☐ Occurrence ☐

Caller's First & Last Name: ____________ Caller's Telephone Number: ____________

Injured Employee's Employment Status: Full Time ☐ Part Time ☐ Volunteer ☐ Other ☐

Loss Location Name: ____________

Loss Location Address: ____________ City & State: ____________ Zip Code: ______

INJURED EMPLOYEE'S INFORMATION

Employee's First & Last Name: ____________

Employee's Home Address: ____________ City & State: ____________ Zip Code: ______

Employee's Social Security Number: ____________

Employee's Telephone Numbers Work: ____________ Home: ____________

Gender: Male ☐ Female ☐ Date of Birth: ____________ Job Title: ____________

Department: ____________

Supervisor's Name: ____________ Telephone Number: ____________

Employee's Hire Date: ____________

Did employee miss work beyond normal shift? Yes ☐ No ☐ If yes, continue below

Last Day Worked: ____________ Disability Date: ____________ Returned to Work: ____________

Time Employee Began Work: ____________ Date Employer Notified: ____________

Loss Description: ____________

Injury Type: ____________ Cause of Injury: ____________ Body Parts Involved: ____________

Contact Name: ____________ Telephone Number: ____________

TREATMENT INFORMATION (If Known)

Name of Physician: ____________ Physician's Telephone Number: ____________

Name of Hospital: ____________ Hospital Telephone Number: ____________

WITNESS

Name: ____________ Address: ____________

City & State: ____________ Zip Code: ______ Telephone Number: ____________

CLAIM NUMBER: ____________

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