EMPLOYEE INJURY

Workers' compensation claim worksheet

Employer					
Name and address of employer				Policy number **WC6-Z91-460156-032**	Location code
Accident date	Accident time	City and county where accident occurred			

Employee					
Name and address of employee				Phone number	Social Security Number
Age	Date of birth	Marital status	Job title	Regular department	Hire date

Accident information				
Date accident reported to supervisor	Est. days off work	Hours worked/days	Days/week	Hourly wage/Weekly salary
Manager/supervisor name	Last day employee worked	First day off work	If fatality, date of death	
Has employee returned to work?	If yes, date returned	If no, estimated return to work date		
Description of work-related injury/illness			Part of body injured	
Were safety guards, personal protective equipment provided and used? Comments:				
Do you have any reason to doubt the validity of this claim? Comments:				

Witness	
Name and address	Phone number

Physician	
Name and address	Phone number

Hospital	
Name and address	Phone number

Other		
Number of dependents	If death, next of kin	Next of kin mailing address/phone

This form is intended to be used as a worksheet to collect data you will be requested to provide when reporting a claim. It is not intended to replace any state required report. Your carrier will ensure that the proper state form is completed and filed.

Report WC claims to Liberty Mutual. Phone: 800-266-2800. Fax: 800-329-3297.

If you have any questions regarding a claim, contact Lori Phillips with Wells Fargo at 404-923-3558 or lori.phillips@wellsfargo.com