

Workman's Comp Injury Report Form
Fill out and return to Salli Jenks within 24 hours of injury

I. Claimant Information:

Last/first/middle Name _____

Sex _____ Birthdate _____ SS # _____

Home Address, City, State, Zip _____

Home Phone _____ Marital Status _____ Number of dependents _____

Occupation _____ Dept. _____

II. Accident Information:

Date of accident _____ Time of injury _____

Accident description: _____

Did accident occur on your premises? _____ Accident Location _____

City/State/ZIP Code: Lincoln NE 68506 County: Lancaster Last Day Worked _____

Witnesses: _____

Date returned to work _____ If employee died, date of death _____

Date employer notified of injury _____ Date of hire/State of hire _____ Nebraska

III. Class Code:

Body Part _____ Injury Description _____

IV. Wage Information:

Average weekly gross wage _____ Average hours per day/week _____

Other Compensation None Full pay last day worked? _____ Salary Continued _____

Hourly wage rate _____

V. Medical Information:

Name of physician or clinic _____

Address/City/State/ZIP Code of Physician _____

Physician's Phone Number _____