TO BE COMPLETED BY THE INJURED EMPLOYEE

EMPLOYEE INFORMATION

NAME: SSN: GENDER ☐ M ☐ F HOME PHONE:

ADDRESS: CITY: STATE: ZIP:

BIRTHDATE:

EMPLOYMENT HISTORY

OCCUPATION: DEPARTMENT: DATE HIRED:

ACCIDENT INFORMATION

DATE OF INJURY: TIME OF INJURY: DATE REPORTED:

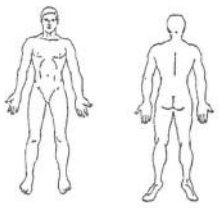
NAME OF INDIVIDUAL THE INJURY WAS REPORTED TO:

IN YOUR OWN WORDS, EXPLAIN IN DETAIL WHAT YOU WERE DOING IMMEDIATELY BEFORE THE ACCIDENT AND HOW THE ACCIDENT OCCURRED:

WITNESS?: DID/WILL YOU SEEK MEDICAL TREATMENT? (CLICK) **YES** **NO**

IF YES, PLEASE PROVIDE PHYSICIAN:
CLINIC:
PHYSICIAN:
ADDRESS:
PHONE:

INDICATE ON THE DIAGRAM THE LOCATION OF INJURY



DESCRIBE SYMPTOMS:

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

DATE: SIGNATURE:

EMPLOYER SECTION:

PLEASE CHECK ONE:

EMPLOYEE HAS NOT MISSED TIME FROM WORK ☐
EMPLOYEE IS OFF WORK ☐

IF EMPLOYEE IS OFF WORK, PLEASE INDICATE REASON

AUTHORIZED OFF WORK ☐
WORK RESTRICTIONS ☐

PLEASE SUBMIT REPORT TO:

COUNTY	GREEN
NAME	HUMAN RESOURCES DEPARTMENT
PHONE	608-328-9645/328-9655
FAX	608-325-1162

PLEASE BE SURE TO ATTACH A COPY OF THE PHYSICIAN'S RETURN TO WORK REPORT IF AVAILABLE

FAX REPORT TO AEGIS CORPORATION AT 262-252-6579 WITHIN 24 HOURS

SUPERVISOR OR HR REPRESENTATIVE: PHONE: