# Business Insurers of Georgia

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(Name of BIofGA's Client Employing Injured Worker)

## EMPLOYER'S REPORT OF INCIDENT

**COMPLETE ALL BLANKS**

**Date of This Report:** _____ **Date of Incident:** _____

**Name of Injured Worker:** _____ **SS#:** _____

**Birthdate:** _____/_____/_____ **Date Employee Reported Incident:** _____

**Home Address:** _____ **Phone #:** _____

**City, State, ZIP:** _____ **Hire Date:** _____

**Does the injured worker have: Health Insurance?** _____ **Pre-Existing Conditions?** _____

**Injured Worker's Occupation:** _____ **Pay Rate:** _____

**Is Injured Worker Part-Time of Full-Time?** _____ **Full pay on day of injury?** _____

**Days Injured Worker Typically Works:** _____

**Time of Incident:** _____ **Time Employee Reported for Work Day of Incident:** _____

**Person Employee Reported Incident To:** _____

**Client Where Incident Occurred:** _____

**Address Where Incident Occurred:** _____

**Was the Injured Worker administered a drug test immediately following the incident?** _____

**If yes, what were the results?** _____ **(Please send a copy of results)**

**Has employee lost time from work? (If yes, give dates of lost time and if employee has returned to work)**

_____

**Describe the incident in detail (how, why, where, what):**

_____

_____

**Is a third party (another company or individual) responsible for this incident? If yes, please give details:**

_____

**Type of Injury (cut, sprain, bruise, fracture, etc.):** _____

**Which part of body injured (be specific):** _____

**Are there any safety issues that contributed to this injury? If so, please detail:**

_____

**List all witnesses to this incident, including names and phone numbers:**

_____

**Name of Medical Facility Where Employee Taken:** _____

**Phone Number:** _____ **Address of Facility:** _____

**Date of Initial Medical Treatment:** _____

**Do you have any particular concerns with this claim?**

_____

**Name of Employer Contact Completing This Report:** _____ **(Print Name & Phone Number)**

**Employer Contact's Signature:** _____

*******REPORT DUE WITHIN 24 HOURS OF ACCIDENT*******

******Also complete the Employee's Report of Incident******

# Supplemental Questionnaire

**Injured Worker's Occupation:**_____

**Detailed Description of Injured Worker's Job Duties:**_____

_____

**Injured Workers Marital Status:**_____

**Sex of Injured Worker:**_____

**Was a Post-Offer Medical Questionnaire completed at the time of hire?**_____

**Was the injured worker administered an alcohol test after the incident?**_____

***If Yes, what were the results?**_____

**How would you describe this employee's work history?**_____

**Have there been similar incidents involving this employee?**_____

***If yes, please provide details:**_____

_____

**Have there been any disciplinary actions against this employee?**_____

***If yes, please provide details:**_____

_____

**Did this employee report their claim to the employer more than one day after the date of the incident? If so, why?**

_____

**If reporting this incident to BIofGA more than two days after the employee reported this incident to the employer, be prepared to provide additional details for a reason for the delay.**