# Employee's Report of Injury

Vensure Employer Services

**Step 1: Please complete and submit no matter how minor the injury.**

| | | | |
|---|---|---|---|
| **Last Name:** | **First Name:** | **M.I.** | **SSN:** |
| **Street Address:** | | | **Apt.** |
| **City:** | | **State:** | **Zip:** |
| **Phone Number:** | **Email Address:** | | **Date of Birth:** |
| **Employer:** | **Job Title:** | **Department:** | |
| **Injury Reported To:** | **Position:** | **Date Reported:** | |
| **Date of Injury:** | **Last Day Worked:** | **Return to Work Date:** | |
| **Where did the injury occur?** | | | |
| **What were you doing when the injury occured?** | | | |
| **How did the injury occur?** | | | |
| **What object or substance caused the injury?** | | | |
| **Type of Injury:** | | **Part of Body:** | |
| **What type of treatment was received?** | | | |
| **Who witnessed the accident?** | | | |
| **Was the injury caused by someone else?** | | ☐ No | ☐ Yes |
| Name: | | | |
| **Did the accident involve employees or equipment from another company?** | | ☐ No | ☐ Yes |
| **What actions (if any) were taken to prevent similar accidents from occuring?** | | | |
| **Have you had a Workers' Comp claim in the last year?** | | ☐ No | ☐ Yes |
| If Yes, When: | | | |
| **Have you had a previous injury to this body part?** | | ☐ No | ☐ Yes |
| If Yes, When: | | | |

| | | | |
|---|---|---|---|
| **Department:** | | **Job title at time of incident:** | |
| Are you currently going to physical therapy? | | Work schedule: | |
| ☐ Yes | ☐ No | ☐ Regular Full-Time | ☐ Regular Part-Time |
| Are you taking pain medication? | | ☐ Seasonal | ☐ Temporary |
| ☐ Yes | ☐ No | Months with this employer: | |
| Are you taking any other medications? | | Months doing this job: | |
| ☐ Yes | ☐ No | | |
| If yes, please list all medications: | | | |

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**Step 2: Pain chart.**

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

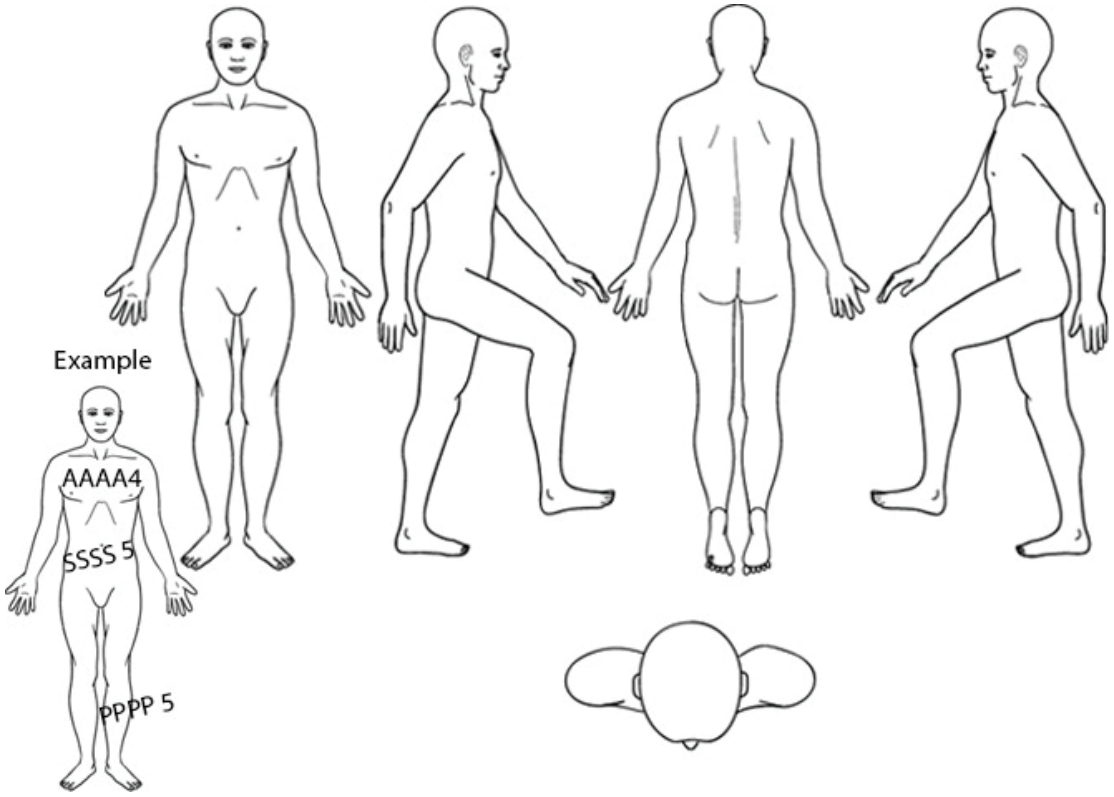
| **Description:** | Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|---|
| **Symbol** | NNNN | PPPP | BBBB | AAAA | SSSS |

**Nature of injury: (most serious one)**

| | | | |
|---|---|---|---|
| ☐ Abrasion, scrapes | ☐ Amputation | ☐ Broken bone | ☐ Bruise |
| ☐ Burn (heat) | ☐ Burn (chemical) | ☐ Concussion (to the head) | ☐ Crushing Injury |
| ☐ Cut, laceration, puncture | ☐ Hernia | ☐ Illness | ☐ Sprain, strain |

☐ Damage to a body system: (e.g. nervous, respiratory, or circulatory system):

☐ Other:




*Note: Any person who knowingly provides false, incomplete, or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.*

Employee Name (print)

Employee Signature

Date

**Please fax completed form to (480) 289-6220 or email to WCNewClaims@vensure.com**