



## Injury Data Collection Form

**Instructions:** Injured employee's supervisor immediately completes form following work related injury and sends to agency staff responsible for reporting work related injury to third party administrator (CorVel) via CareMC web portal.

Employee's name:		Date of Birth:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:			
Home phone:		Work phone:	
Social security number:			
Location where the injury occurred:		What county was employee injured in?	
State Agency:		Division Name:	
Date of injury:	Day of the week:	Hour of the day:	
Did injury occur on employer's premises? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was the employee paid for the entire day? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Date supervisor knew of the injury:	Name of supervisor:		
Occupation of injured employee:			
Date employee hired:			
Number of hours worked per day:			
Describe fully how injury occurred and what employee was doing at the time of the injury:			
What part and side of the body was injured?			
Did employee return to work? Yes <input type="checkbox"/> No <input type="checkbox"/>	When did employee return to work?		
Was employee treated by a physician? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this a report only with no medical treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Time the employee started work the day of the injury:			
Where did injured employee go for treatment (Facility name, address and phone number)?			
Was this an ER visit? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did injury require an overnight stay? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Was the injury caused by another person? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was this due to an assault? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you question the validity of this claim? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If so explain why:			