UMIALIK INSURANCE COMPANY

A member of the Western National Insurance Group

EMPLOYEE INCIDENT REPORT FORM

This form is to be completed by the Supervisor

IMMEDIATELY REPORT ALL ACCIDENTS THAT REQUIRE MEDICAL TREATMENT AND FILE A FIRST REPORT OF INJURY TO WESTERN NATIONAL INSURANCE

EMPLOYEE INFORMATION

Name: _____ Birthdate: _____ Soc. Sec No. _____
First MI Last

Address: _____ Zip_____ Phone: (____)_____
Street City State

Job Title: _____ Hire Date: ___/___ Marital Status: ☐ Married ☐Not Married
MO YR

Location where accident occurred: _____
Jobsite Address

Date of Accident: _____ Time of Accident: _____ ☐AM ☐PM

Accident/Injury Reported to: _____on_____.
Office/Supervisor Date

Did you lose work time? ☐ NO* ☐YES First Day of Lost Time: _____
Hours Lost on First Day: _____
Return to wok Date*: _____

Describe injury and body part involved: _____
Describe what you were doing and how the injury occurred: _____
_____
_____
_____

Medical Status:
- ☐ No Medical Care Needed
- ☐ On-Site First Aid
- ☐ Off-site Medical Treatment

Physician/Clinic Name: _____ Initial visit: _____

Employee Signature: _____ Today's Date: _____

*Report any additional or subsequent lost work time to your Supervisor and Western National Insurance immediately

SUPERVISOR INFORMATION

Date Employer/Supervisor Notified of Incident: _____
What action has been taken to prevent a similar incident from recurring:
_____
_____
_____
Date Corrective Action was completed: _____

Supervisor's Signature: _____ Phone: _____ Today's Date: _____