

PLEASE COMPLETE THIS FORM WITHIN 24 HOURS OF YOUR WORK-RELATED INJURY, MAIL OR FAX COMPLETED FORM TO THE DIOCESE OF SIOUX CITY, PO BOX 3379, SIOUX CITY IA 51102-3379 OR 712-233-7528 IMMEDIATELY.

EMPLOYEE'S WORK INJURY REPORT

PERSONAL

Name _____ Social Security Number _____ - -
Address _____ Birthdate _____ M F
City State _____ Zip _____ Telephone () -
Married Single Number of children at home _____

EMPLOYMENT

Job Title _____ Employment Date _____
Salary/Hourly Rate \$ / _____ Hours Worked Per Day _____
Building Location _____ Time Work Day Begins _____

INJURY/ILLNESS

Date of Injury _____ Time of Accident _____
Where did this injury occur _____
What were you doing when injured? _____
How did the injury occur? _____
Describe the injury or illness in detail and indicate the part of the body affected (Designate right or left if appropriate)

Any previous similar injury? If yes, explain. _____
Was this injury witnessed? If so, by whom? _____

TREATMENT

Designated Medical Treatment Center _____
Diagnosis/Care Prescribed _____
Family Physician _____ Telephone Number () -
Did you lose time from work? Yes No If yes, what was the date? _____

CONTACT

You must notify the Diocese Risk Management Coordinator **DEB BREAMAN**
When you return to work call **712-233-7548**
You must also return this completed form to the Diocese Risk Management Coordinator.

Employee Signature

Date

Date Employer was Notified of Injury