



Internal Use Only Date Received: _____
 Claim sent to () WC Insurance Carrier date: _____ () Mailed () Telephoned
 Claim Number: _____ W/C Contact: _____ Initials: _____

IMPORTANT! If a workplace injury or illness is reported to you, immediately refer the injured employee to the pre-designated medical clinic. All incidents, regardless of severity, must be reported to DynamicHR within 24 hours. Please complete this form and fax it to DynamicHR at 248-370-0968.

THERE ARE STRICT TIME PERIODS IN WHICH ALL CLAIMS MUST BE REPORTED. LATE REPORTING MAY RESULT IN FINANCIAL PENALTIES IMPOSED BY THE STATE.

Employee Information:

Employee: _____ Social Security Number: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 Marital Status: Married () Single/Divorced () Number of Dependents: _____
 Does the injured employee speak English? Yes () No ()
 Date of Birth: ____/____/____ Date of Hire: ____/____/____
 Job Title: _____ Hours Worked in Average Day: _____ Days Worked in Average Week: _____

Worksite Employer Information:

Worksite Employer Name: _____ Worksite Employer Contact: _____
 Worksite Employer Contact Phone: _____ Cell: _____

Accident Information:

Date of incident/accident/injury/illness: ____/____/____ Date reported to Dynamic: ____/____/____
 Time Employee Began Work on Date of Incident: _____AM PM Time of Incident: _____AM PM
 Address where the accident/injury/illness occurred: _____
 County where the accident/injury/illness occurred: _____
 Describe the injury or illness (i.e. cut on hand, fractured finger, object in eye): _____
 Part of body directly injured (i.e. back, **left** wrist, **right** eye): _____
 Has the employee died? () Yes () No If yes, date of death: _____

Did the employee receive medical treatment? No () Yes ()

If yes, where? _____ Contact Name: _____

Address: _____ Phone: _____

Did the employee miss any work? Yes () No () Last day employee worked: _____

Has the employee returned to work? Yes () No () Date employee returned to work: _____

Was the employee performing their normal job duties when the incident occurred? No () Yes ()

What was the employee doing before the incident? _____

Incident Description _____

How did the incident occur? (Please describe fully the events that resulted in the incident / exposure. Describe what happened, how it happened and anything about the scene that may have contributed to the incident occurring. Attached additional sheet if necessary)

Name of witnesses to incident / exposure (First and Last name and telephone numbers):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Do you question the validity of the claim of injury/illness? No () Yes () If yes, why?: _____

Additional Comments:

Completed by: _____ Phone: _____ Date: _____