INDUSTRIAL COMMISSION OF ARIZONA

800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

WORKER'S REPORT OF INJURY

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.azica.gov

ANSWER ALL QUESTIONS FULLY

1. NAME OF INJURED WORKER: LAST FIRST M.I.
   SOCIAL SECURITY # *: BIRTH DATE: PHONE #:
2. ADDRESS: CITY STATE ZIP CODE
3. MARITAL STATUS: SINGLE ◯ MARRIED ◯ DIVORCED ◯ DEPENDENTS AT TIME OF INJURY: YES ◯ NO ◯
4. EMPLOYER: SUPERVISOR:
5. PHONE #: EMPLOYER ADDRESS: CITY STATE ZIP CODE
6. DATE HIRED: WHERE HIRED: OCCUPATION:
7. HOURS WORKED PER DAY: PER WEEK: HOURLY WAGE:
8. DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE? YES ◯ NO ◯
9. DATE OF INJURY (MO/DAY/YEAR): TIME OF INJURY: AM ◯ PM ◯
10. ADDRESS OR LOCATION OF ACCIDENT:
11. DID YOU STOP WORK IMMEDIATELY? WHEN DID YOU STOP?
12. WHEN DID YOU REPORT THE INJURY? TO WHOM? TITLE:
13. WHEN DID YOU RETURN TO WORK? REGULAR WORK OTHER WORK
14. NAMES OF PERSONS WHO SAW THE ACCIDENT.
    1. NAME: ADDRESS: PHONE #:
    2. NAME: ADDRESS: PHONE #:
15. WAS ACCIDENT CAUSED BY ANOTHER PERSON? IF SO, BY WHOM?
16. NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT:
17. STATE HOW ACCIDENT HAPPENED:

18. BODY PART INJURED: DESCRIBE THE INJURY (CUT, BRUISE, ETC.):
19. WHERE WERE YOU FIRST TREATED: NAME: ADDRESS:
20. WHO TREATED YOU FOR THIS INJURY: NAME: ADDRESS:
21. OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS? YES ◯ NO ◯
    NAME OF STATE WHERE ACCIDENT HAPPENED: WORK INJURY: YES ◯ NO ◯
22. OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY? YES ◯ NO ◯
    DATE OF INJURY: WORK INJURY: YES ◯ NO ◯
    NAME OF STATE WHERE ACCIDENT HAPPENED:
23. OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS? YES ◯ NO ◯
    IF SO, FROM WHOM? AMOUNT? WHY?

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

Signature of injured worker or injured worker's authorized representative is REQUIRED. **Date**

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

Submitter Email Address

Employer Email Address: **Worker Email Address:**

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602 542-4661).