Prior to completion contact Innovative Risk Concepts, Inc.
Note: You may copy this form onto your letterhead

Workers' Compensation Incident Report

NYSIF Policy Number: ________________________

This report and the information contained herein is for informational purposes only. Since this injury currently does not involve lost time of more than (1) day beyond the day of injury or more than (2) treatments by a doctor, we intend to self retain related medical bills. If any changes concerning this injury occur we will promptly advise you. Please note the following:

Name of Employee: _____________________________ DOB: ___________________

Employee's Address:__________________________________ S.S. #____________

Date of Accident:______________ Male/Female , Date of Employment:_________

Employee's Job Title/Dept:____________________ Normal Working Days:_________

Full/Part Time Employee:____________ Time Employee Began Work:____________

Part of Body Injured:______________ Nature of Injury:________________________

Where Did Injury Occur:____________________________ Time of Injury:__________

What was the employee doing when injury occurred: ____________________________

____

Employer:________________________ Location of Facility:____________________

Employer's Phone Number:__________________ Fax Number:________________

Treating Doctor/Hospital: ____

Person Completing Form (Print):____

Signature: _________________________ Title: ____________________________

Date of Report:__________________ Date Notified of Injury:___________________

Please contact the Claims Department at Innovative Risk Concepts, Inc. at (201)-652-2015 if you have any questions.

06/2010