Employee's Report of Injury

HUMAN CAPITAL
A Vensure Employer Services Company

Step 1: Please complete and submit no matter how minor the injury.

Last Name:	**First Name:**	**M.I.**	**SSN:**
Street Address:			**Apt.**
City:		**State:**	**Zip:**
Phone Number:	**Email Address:**		**Date of Birth:**
Employer:	**Job Title:**	**Department:**	
Injury Reported To:	**Position:**	**Date Reported:**	
Date of Injury:	**Last Day Worked:**	**Return to Work Date:**	

Where did the injury occur?

What were you doing when the injury occured?

How did the injury occur?

What object or substance caused the injury?

Type of Injury:	**Part of Body:**

What type of treatment was received?

Who witnessed the accident?

Was the injury caused by someone else?	☐ No	☐ Yes
Name:		
Did the accident involve employees or equipment from another company?	☐ No	☐ Yes

What actions (if any) were taken to prevent similar accidents from occuring?

Have you had a Workers' Comp claim in the last year?	☐ No	☐ Yes
If Yes, When:		
Have you had a previous injury to this body part?	☐ No	☐ Yes
If Yes, When:		

Department:		**Job title at time of incident:**	
Are you currently going to physical therapy?		Work schedule:	
☐ Yes	☐ No	☐ Regular Full-Time	☐ Regular Part-Time
Are you taking pain medication?		☐ Seasonal	☐ Temporary
☐ Yes	☐ No	Months with this employer:	
Are you taking any other medications?		Months doing this job:	
☐ Yes	☐ No		
If yes, please list all medications:			

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Step 2: Pain chart.

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

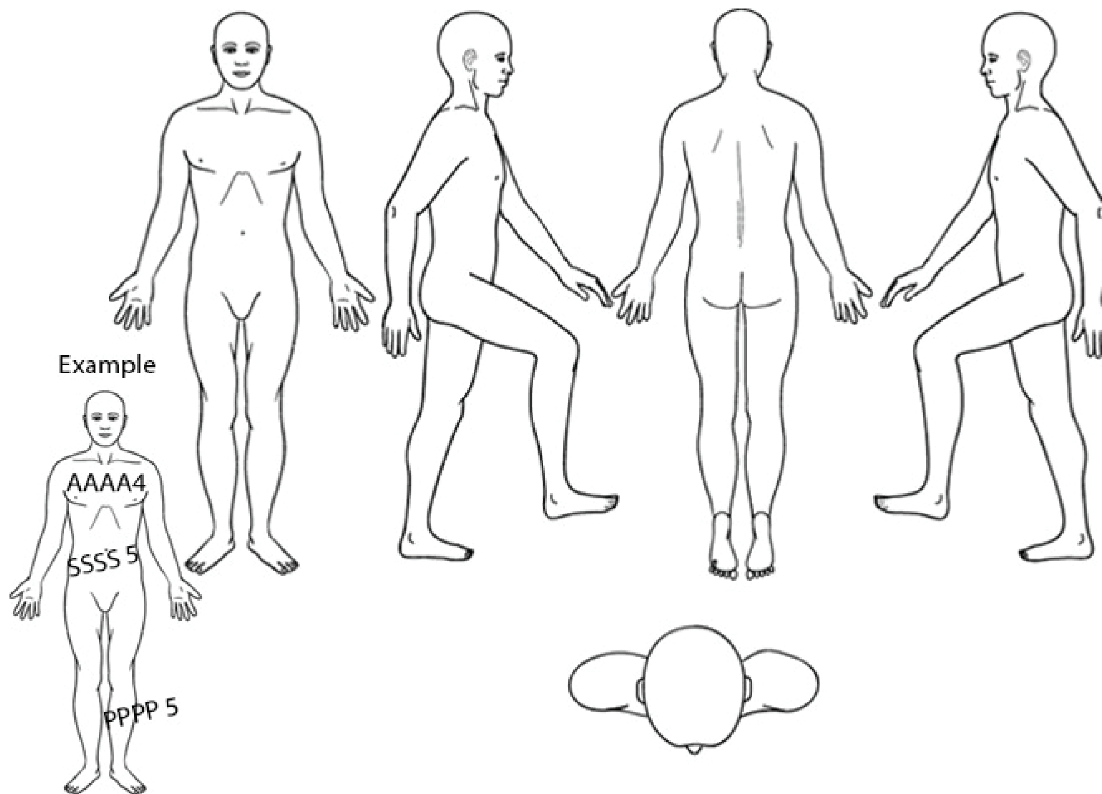
Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol	NNNN	PPPP	BBBB	AAAA	SSSS

Nature of injury: (most serious one)

☐ Abrasion, scrapes	☐ Amputation	☐ Broken bone	☐ Bruise
☐ Burn (heat)	☐ Burn (chemical)	☐ Concussion (to the head)	☐ Crushing Injury
☐ Cut, laceration, puncture	☐ Hernia	☐ Illness	☐ Sprain, strain

☐ Damage to a body system: (e.g. nervous, respiratory, or circulatory system):

☐ Other:



Note: Any person who knowingly provides false, incomplete, or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.

Employee Name (print)

Employee Signature

Date

Please fax completed form to (480) 289-6220 or email to WCNewClaims@Human-Capital.com.

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