WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ. 85005-9070

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.ica.state.az.us

ANSWER ALL QUESTIONS FULLY (Use the back of this form to indicate any further information.)

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'S FULL NAME: ______________________ PHONE #: __________
5. 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.

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).