CIRMA care

CIRMA Injury Reporting Information

Event Date/Time

Incident Date and Time: _____   Employer Notified: _____

Reporter & Location Information

Reported by: _____   Title: _____   Phone Number: _____

Location Code: _N/A_   Location Name: _____   Address: _____

Claimant Information

Social Security Number of Claimant: _____

Claimant Name: _____

Home Phone: _____   Work Phone: _____

Home Street Address: _____

City: _____   State: _____   Zip: _____

Date of Birth: _____   Marital Status: _____   Gender: ☐ Male   ☐ Female

Employment

Job Title: _____   Status: _____

Claimant's Supervisor: _____   Title: _____   Phone: _____

Incident

Description of the Injury: _____

€include exact location € _____

Cause: _____   Body Part: _____

Nature Code: _____

Medical Provider (if known): _____   Address of Medical Provider: _____

Name of Doctor (if known): _____

Witness Name (if any): _____

Lost time from work (if known): _____   Return to work date: _____

Loss Location Entity: _N/A_

Address: _N/A_

Contact Person: _N/A_

Additional Information

Job Classification code: _____

Time the employee began work on the day of injury: _____

Supervisor Notice Date: _____   Claim Incident Number: [_____]   *office only*

This is assigned by NetClaim.net (at the FINISH tab) or by the Hotline operator.   Rev. 021014