WC Work Site & Injured Worker Reporting Form

INJURED WORKER TO COMPLETE			
Injured Worker's Name:			
Address:			
City:	State:	Zip:	Phone #:
SSN:	Gender:	Spouse:	Dependants:

WORK SITE TO COMPLETE	
Customer Name:	
Supervisor Name:	Witness Name:
Phone Number:	Fax Number:
Prior to Injury Was the Worker trained on job procedures: ___ NO ___ YES Date:	Post Injury Was Worker counseled on the job procedures: ___ NO ___ YES Date:
Any plans to correct work procedures to help prevent this from happening again:	

INJURY INFO TO BE COMPLETED BY SIGNING PARTY			
Work Site:			
Injured Worker Name:			
Injured Worker Job Title & Duties:			Date of Hire:
Date of Injury:	Time Employee Began Work:	Time of Injury:	Date Notified of Injury:
Full Pay for Day of Injury?	Last Day Worked:	Date Disability Began:	Date Returned To Work:
Witnesses to Injury:			
Part of Body Injured:			
How Injury or Illness / Abnormal Health Condition Occurred. Describe the sequence of events and include any objects or substances directly responsible:			
Were Safeguards or Safety Equipment Provided?		Were Safeguards or Safety Equipment Used?	
All Equipment, Materials or Chemicals Worker was using when Accident or Illness Exposure Occurred:			

Injured Worker Signature:	Date:
Customer Signature:	Date:

This form is part of Alternative Staffing's Workers' Compensations Injured Worker's Reporting Program and once completed needs to be mailed to our Corporate Office at: 902 Steen Road, Pittsburgh, PA 15017 or faxed to: 412-221-2193 for proper filing.