WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ. 85005-9070
Do not attach form to email; mail in envelope to address above or FAX to 602-542-3373.

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).

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