Employee Injury or Illness Notification

The **employee** must complete the *Employee Injury or Illness Notification*. The employee's supervisor must then sign, date and return the form to the IMWCA Claims Department at 500 SW 7th Street, Suite 101, Des Moines, IA 50309. For questions on how to complete this form, contact IMWCA Claims Division at (515) 244-2708 or (800) 257-2708.

Employee Information (please print or type)

Name: ____ Social Security No: ________________

Address: _______________________________________ City: ________________________________

Zip Code:____________ Home Phone: (   )_____-____________ Date of birth:____/____ /____

Sex:_____ Occupation: ______________________________ Length of Employment: ______________

Employer: ____

Accident Information

Date and time of injury:________________________ Date and time injury reported:________________

How did the accident happen? (please describe in detail)

____

____

____

____

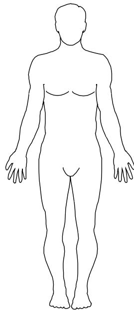
To whom did you report the accident? (list names)

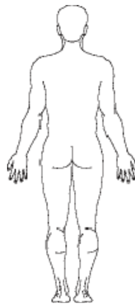
____

Who was present when the accident occurred? (list names)

____

Indicate the injured part(s) of your body (specify right or left):





Have you ever injured this part of your body before? YES NO

If yes, please describe:

____

____

Treatment Information

Does your employer require the use of a designated physician for workers' compensation injuries?
YES NO
If so, list doctor's name: ____

From whom did you first receive medical treatment?____

Phone Number: ( )______-____________

Street address of facility: ________________________________ City:______________________

Street address of facility: ________________________________ City:______________________

Date of first treatment:______________________ Are you still receiving treatment? YES NO
If yes, explain the type, frequency and length of anticipated treatment:

____

____

____

____

Return to Work

Did you miss more than three days of work? YES NO
If no, skip the rest of the questions, and sign the form.

On what date did you return to work?______ If not working, when do you expect to return to work?_____

Has your physician placed restrictions on your activities? YES NO
If yes, explain:

____

____

Is there any job you can do with these restrictions? YES NO
If yes, what job?____

____

Did you discuss light duty with your supervisor? YES NO

The information in the box below must be completed if the employee missed more than three days of work.

*This wage information and maximum exemptions are used to calculate workers' compensation rates for compensable claims. BE AS ACCURATE AS POSSIBLE.

Marital Status:__________
Are you 65 or older?__________
Is your spouse 65 or older?__________
Are you blind? __________
Is your spouse blind?________
Number of dependent children:__________
Other dependents?__________
Number of hours you normally work each week:__________

Are your earnings based on hourly wages?
If so, $_________x___________= $________
(hourly rate) (no. of hrs)

If not based on hourly wages, show weekly earnings and how computed: ________________= $_______

If gross wages vary, supply total earnings for last completed period of 13 weeks: _____________ 13 weeks = $ _______

Wage documentation must be attached to this report for all lost time claims.

______________________________________ ______________________________________
Employee's Signature (date signed) Supervisor's Signature (date signed)

Please fax or e-mail this completed form to (978) 367-2862 or imwcaclaims@iowaleague.org