

REPORT ALL WORKER'S COMPENSATION INJURIES TO LIBERTY MUTUAL INSURANCE
 The 1-800 CLAIMS SERVICE CENTER is open 24 hours a day including
 Weekends and Holidays. For efficient service, have the following
 information available for the Customer Service Representative.



Call: 1-800-362-0000

ExPRSCall W C Report Form

CLAIM INFORMATION

Date/Time of Injury: / / : am pm	After the call, write claim number here	WC
Is this claim work related? Yes <input type="radio"/> No <input type="radio"/>	Will the employee miss time from work? Yes <input type="radio"/> No <input type="radio"/>	

Employer Name:

EMPLOYEE INFORMATION

Employee's Social Security Number: - - - -	Employee's Name:	
Home Address: (Street) (City) (State) (Zip)		
Home Phone Number: () - - - -	Male <input type="radio"/> Female <input type="radio"/>	
Date of Birth:	Marital Status (circle one) Single Married Widowed Divorced	
Hire Date:	Number of Dependents: Dependents Under 18:	
Occupation:	Department Name:	
State Hired:	Supervisor Name & Phone:	
Current Weekly Wage:	Hourly Wage:	Hours Worked Per Week:
Days Worked Per Week:	Hours Worked Per Day:	Employment Status:
Employer Report No:	Employee ID No:	Was Salary Continued:
Was Employee Paid in Full for Date of Injury:	How often is employee paid:	
Education Level:	Any Prior WC Injuries:	OSHA Reference No.:

EMPLOYER INFORMATION

Contact Name, Telephone Number, and Title:	
Work Location: (Street) (City) (State) (Zip)	
Mailing Addr: (Street) (City) (State) (Zip)	
Employer Location Code:	Employer SIC.:
Employer FED ID.:	Employer Code:
Nature of Business:	
Policy Number:	

ACCIDENT INFORMATION

Did the Accident Occur at the Work Location? Yes <input type="radio"/> No <input type="radio"/> If no, where did the accident occur?	
Accident Address: (Street) (City) (State) (Zip)	
Nature of Accident:	
Give a Full Description of the Accident: (Be As Complete As Possible)	
Are Other WC Claims Involved? Yes <input type="radio"/> No <input type="radio"/>	Date and Time Reported to Employer: : AM/PM
Person Reported To:	

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

Injury Description:

Date of Death (If applicable):	Is Employee Hospitalized? Yes <input type="radio"/> No <input type="radio"/>
Lost Time? Yes <input type="radio"/> No <input type="radio"/>	If yes, What was First Full Day Out:
Date Last Day Worked:	Date Disability Began:
Date Returned to Work:	OR Estimated Return to Work Date:
Time Workday Began: : AM PM	
Which Part of the Body Was Injured? (e.g. Head, Neck, Arm, Leg)	Nature of Injury (e.g. Laceration, Bruise, Fracture)
Part of Body Location: (e.g. Left, Right, Upper, Lower)	Source of Injury:

MEDICAL INFORMATION

Safeguards Provided? Yes <input type="radio"/> No <input type="radio"/>	Safeguards Utilized? Yes <input type="radio"/> No <input type="radio"/>
Initial Medical Treatment: Circle One ER Treated and Released Hospitalized Physician/Clinic Minor/Onsite No Medical Treatment	

Hospital - Name, Address, Phone, Fax:

Clinic/Doctor - Name, Address, Phone, Fax, Specialty:

WITNESS INFORMATION

Were There Any Witnesses? Yes No

If Yes, List Names and How to Contact Them:

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY

Name:

Title:

Signature:

Phone: () -