WORKER'S COMPENSATION REPORT

PLEASE PRINT CLEARLY

Summit Insure 610-356-0400 X104 for claims

When completed fax to 610-356-1794 or email cbaker@summitinsure.com

Company Name and Address			
State Of Employment			Date of Accident
Employer contact Name and Phone Number			Time of Accident AM PM

EMPLOYEE/INJURED INFORMATION

Name			
Address City State and Zip			
Phone, include any cell phone numbers			
Birthdate	Age	Social Security Number	
Circle all that apply: male female single married divorced widowed full time part time commission salaried hourly			
Occupation	Date Hired	Average Weekly Wage	Union #
Complicating Medical Conditions: i.e. diabetes, high blood pressure, asthma, etc			

ACCIDENT INFORMATION

Date Employer Notified	**Claim is:** no injury	Jobsite medical	Clinic medical	Hospital released	hospital inpatient	death	Lost Time	Modified Duty
Accident Description:								
Witnesses:								

Location of accident:	Injuries:
Is this a questionable accident: yes no	Date Returned to Work:
Subrogation: Is any person, company or machinery responsible for injury: yes no If Yes, Give details:	
Any additional Information:	
Name and Signature of Person Completing Report	Today's Date: