WORK COMP INJURY/ACCIDENT FORM

Instructions: Please fill out all information to the best of your ability. For ease of use, you can TAB to all answer fields. Email the completed form to: iTAKE2@TRISTARGROUP.NET. Please remember to use the "SAVE AS" functionality so that you keep a clean copy for future use.
Make sure that you complete the Subgroup Coding Fields on row 21.

Updated Nov2021

EMPLOYEE INFORMATION									
EMPLOYEE NAME:						SSN NUMBER:			
GENDER:		MARITAL STATUS:		DATE OF BIRTH:		NO. OF DEPENDENTS:			
HOME ADDRESS:				CITY:		STATE & ZIP:			
HOME PHONE:									

WORK INFORMATION									
EMPLOYER NAME:	Parking Concepts, Inc.								
WORK ADDRESS:				CITY:		STATE & ZIP:			
WORK PHONE:				EE ID #:		DEPT:			
SUPERVISORS NAME:				SUPERVISORS PHONE:					
STATE OF HIRE:		HIRE DATE:		JOB TITLE:					
EXEMPT / NON-EXEMPT:		WAGE PERIOD (HRLY, WKLY, ANNUAL)				PAY RATE:			
EMPLOYEE REGULAR SHIFT:									
HOURS WORKED PER DAY:			DAYS PER WK:			HOURS PER WEEK:			
Org Code 1 = LID Code		**Org Code 2 = SBG Code**		**Org Code 3 = SBU Code**					

LOSS INFORMATION							
* STATE WHERE ACCIDENT OCCURRED:				* DATE OF ACCIDENT: MM/DD/YY			
* DATE EMPLOYER NOTIFIED: MM/DD/YY				Reported to :			
IF CA, WAS A CLAIM FORM PROVIDED?							
* DID ACCIDENT OCCUR ON THE PREMISES?		YES		If **NO**, enter **LOSS LOCATION** address below:			
LOSS LOCATION NAME & ADDRESS:							
CITY, STATE, ZIP:				TIME EE BEGAN WORK:			
* TIME OF ACCIDENT:			AM		PM	LOST TIME?	
LAST DAY WORKED: MM/DD/YY				FIRST DAY OF LOST TIME:			
DATE RETURNED TO WORK: MM/DD/YY							
*FULL PAY FOR DAY OF INJURY?		YES		NO		UNKNOWN	
SALARY CONTINUED DURING DISABILITY?		YES		NO		UNKNOWN	
* DESCRIPTION OF ACCIDENT:	cummulative injury to the back and hips						
* DESCRIBE INJURY OR ILLNESS:	cummulative injury to the back and hips						
* BODY PART INJURED? (indicate right or left)							
WAS THIS A FATALITY?		YES		IF YES, GIVE DATE:			
SAFEGUARDS/SAFETY EQUIP PROVIDED?		YES		NO		UNKNOWN	
SAFEGUARDS/SAFETY EQUIP USED?		YES		NO		UNKNOWN	

PHYSICIAN INFORMATION		HOSPITAL INFORMATION	
NAME:		NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP CODE:		CITY, STATE, ZIP CODE:	
BUSINESS PHONE:		BUSINESS PHONE:	

WITNESS INFORMATION			
NAME:		NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP CODE:		CITY, STATE, ZIP CODE:	
PHONE:		PHONE:	

PREPARER'S NAME:		PREPARER'S PHONE #:			
ARE YOU QUESTIONING THE INCIDENT?		PAYROLL RISK STATE:		CLASS CODE:	

COMMENTS/REMARKS