Workers Compensation Reporting Form

Company: **Flynn Management Corp., 516 Lakeview Road, Unit 8, Clearwater, FL 33756 727-449-1182**

Location Codes Date of loss: _____

Account:

State: where injury occurred _____

Employee Name: _____

Address: _____ SSN: _____

Phone: _____ Date of Birth: _____ Male/Female _____

Regular position: _____ Property: _____

Was employee performing regular duties of the position: _____

Job class code: 8810 clerical, 9012FL, 9012 GA - managers, 9015FL, 9015GA-maintenance

Was employee injured while on the job: _____

Language spoken by employee: _____

Marital Status _____

Number of dependents: _____ Number of dependents under 18 yrs.: _____

Is the employee an owner, partner or officer of the company: _____

State in which employee was hired: _____

Does employee require ADA accommodations: _____

Employment status: full-time or part-time _____

Hire date with company: _____

Hire date in current position: _____

Does employee have group health insurance: _____

Number of hours scheduled per day: _____ number of days per week: _____

Wage information: _____ hourly _____ monthly

Was the employee paid for the full day of the injury: _____

Accident Information:

Date and time of accident: _____ Date and time reported to employer: _____

Who received report: _____

Shift hours: _____

Address where accident occurred: _____

Is this employer's premises: _____

Workers Compensation Reporting Form

Full description of accident: (Include part of body injured: left index finger, right knee, etc.)

Is the accident/incident questionable to employer: _____

Was employee permanently disabled as a result of accident/incident: _____

Does the employer supect drug and/or alcohol use at the time of the accident/incident: _____

Date of death (if fatality): _____

Number of days employee is expected to miss: _____

Last date worked and time employee left work: _____

First day missed: _____

Will the employees salary continue: **only to the extent of sick/vacation days available**

Does the employee have a previous claim: _____

Was any safety equipment provided: _____ was it used _____

Was an unsafe act being performed: _____

If yes, describe: _____

Was a third party responsible for the accident/incident: _____

If so, please provide name, address and phone number: _____

Was accident/incident witnessed: _____

If so, please provide name, address and phone number: _____

Provider:

Was first aid given on site: _____

If yes, what treatment was received: _____

Did employee go to a doctor, hospital or clinic: _____

If so, please provide name, address and phone number: _____

Was employee hospitalized: _____ if yes, date _____

Was employee treated as an outpatient, receive emergency treatment or ambulance service: _____

Claim # Office

Prescriptions:

Name of person submitting report: (Clearwater)

Name: _____ Title: _____ Phone: _____