EMPLOYEE'S REPORT OF INJURY ON THE JOB

(To be filled out by employee only)

Employee Name (Please Print): _____

Date of Injury: _____ Time: _____ AM____ PM _____

What job were you doing when you were injured?

_____

_____

_____

Was anyone with you when you were injured? List their name(s) here:

_____

_____

_____

Briefly describe how you were injured:

_____

_____

_____

_____

_____

What parts of your body were injured?

_____

_____

Was medical treatment away from the job site offered? Yes _____ No _____

If treatment was offered, but declined, **please sign here**: _____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date

_____ _____

Witness Signature Date

SEND ORIGINAL TO:

Claims Administrative Services
Old Glory Insurance Company
P.O. Box 7500
Tyler, TX 75711
Phone: (800) 765-2412
Fax: (903) 509-1888

Please retain a copy for your file

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.