Clear Spring
Property and Casualty Group

Workers' Compensation
REPORT OF INJURY FORM

FILL OUT THIS FORM IN DETAIL. ANSWER ALL QUESTIONS TO ASSURE PROMPT HANDLING OF YOUR CLAIM.

EMPLOYEE PERSONAL INFORMATION:

Full Name | Date of Birth

Address | Phone

Social Security Number | Male ◯ Female ◯

EMPLOYMENT INFORMATION:

Job Title | Name of Employer

Employer's Address | Employer's Phone Number

Date of Hire | Department | Supervisor Name

Number of Days Per Week | Number of Hours Per Day | Hourly Wage Rate or Salary

INJURY INFORMATION:

Date of Injury | Time | Date Injury Reported

Name of the Person you reported the Accident to

Report Claim To: Cannon Cochran Management Services, Inc.
Fax: 1-217-477-5452
Email: clearspring@ccmsi.com
Toll Free: 1-844-975-3466

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_____

Exact Location of your accident (Be Specific)

_____

Describe the accident

_____

What part of your body was injured?

_____

Who witnessed the accident?

MEDICAL TREATMENT INFORMATION:

_____

Where did you first seek medical treatment?

_____

Did you lose time from work/Date of first day missed?

_____

Current treating Doctor Name Phone No:

_____

Doctor's Address Next Appointment date

_____

Have you made a Workers' Compensation claim or received compensation in the past?

SIGNATURE:

_____

Employee Signature Print Name and Phone Number Date

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Employer Signature	Print Name and Phone Number	Date

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