EMPLOYEE'S INJURY REPORT

This form must be completed in detail and signed by the injured employee.

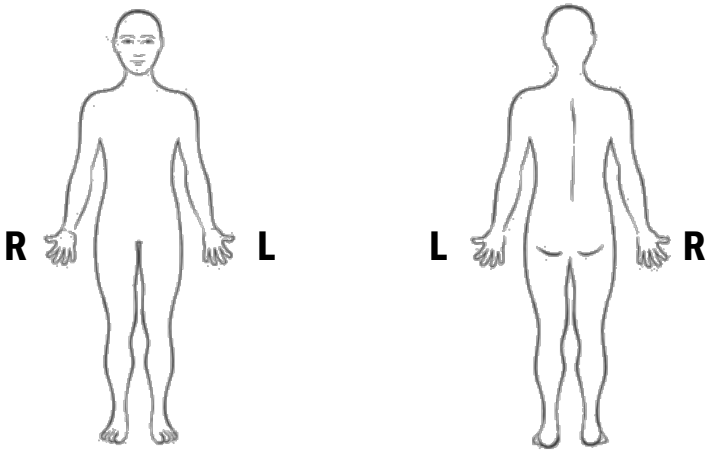
EMPLOYEE INFORMATION

Social Security Number		
Last Name		
First Name		
Gender	Email	
Date of Birth: mm/dd/yyyy	Home Phone	
Mailing Address		
City	State	Zip Code
Marital Status: Single	Spouse's Name	
Number of Dependent Children		
Supervisor's Name	Dept/Division Employed: ADULT SURV/ADULT PROBATIO 2072	
Job Title at Time of Injury	How Long in Current Position? Yrs. Months	
Hire Date: mm/dd/yyyy		

DETAILS OF THE INJURY

Date of Injury: mm/dd/yyyy	Time of Injury AM / PM ☑ ☐
Date You First Lost Time	Nature of Injury: Adverse reaction to a vaccination or inoculation
Part of Body Exposed: Head - Brain	
Did you or do you plan to get any type of medical treatment for your injury	Yes / No ☐ ☐
Name and Location of treatment facility	

On the diagram below, please circle the part(s) of your body where you are experiencing pain due to this injury.



Describe in detail how your injury occurred.

Worksite Location of Injury

Accident Address

Accident City	Accident State	Accident Zip Code

Did anyone witness your accident? Yes	Return to work date/or expected: mm/dd/yyyy

Witness Name	Witness 2 Name	Witness 3 Name

- ✓ **I certify that the information contained in this report is true and correct.**
- ✓ **I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.**
- ✓ **I hereby authorize the release of all medical records relating to the above noted incident to my employer, its agent or insurance company.**

Employee's Printed Name	Employee's Signature	Date

Workers' Compensation Network Acknowledgement Form

I have received the Employee Welcome Letter, Frequently Asked Questions and Notice of Network Requirements, which inform me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the ***IMO Med-Select Network®*.** Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I *may have to pay* the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, *I am still required to use the network*.

Please fill out the following information before signing and submitting this completed acknowledgement form. Injury Management Organization may contact you via phone, email and/or text to provide information to you and/or discuss your work injury.

Name of Employer: Jefferson County **Name of Network:** IMO Med-Select Network®

Employee ID #: **N/A** **Hire Date**: _____ **Department**: _____

Home Address: _____

Street Address – No P.O. Box or Work Address

_____

City **State** **Zip Code** **County**

_____ _____

Printed Name **Employee Phone Number**

_____ _____ _____

Employee Signature **Date** **Email**