

SHORT FORM ACCIDENT REPORT
Occupational Injuries and Illnesses



NOTE: Complete this Short Form for all work-related injuries and illnesses where lost time does **not** exceed seven calendar days.

Employer:

- 1. Name _____ Coverage # _____
- 2. Mailing address _____
City _____ State _____ Zip _____
- 3. Location (if different from mailing address) _____
- 4. Phone number _____

Employee:

- 5. Name _____ Soc. Sec. No. _____
- 6. Home address _____
City _____ State _____ Zip _____
- 7. Phone number _____ 8. Date of birth _____ 9. Sex - M/F _____
- 10. Job title _____ 11. Department _____
- 12. Date of hire _____ 13. Payroll class code _____
- 14. Is Claimant an: Employee? Yes No Subcontractor? Yes No Employee of subcontractor? Yes No

The Accident or Exposure to Occupational Illness:

- 15. Date of illness or injury _____ 16. Last day worked _____
- 17. Date returned to work _____
- 18. Name and address of physician or hospital _____

- 19. Place/address of accident or exposure: No. & street _____
City _____ State _____ Zip _____
- 20. How did the accident or illness occur? (be specific) _____

- 21. Full description of injury or illness (state part(s) of body affected) _____

- Prepared by/official position _____
- Date of report _____

Mail all Claim Reports to:
Sedgwick Claims Management Services, Inc.
P.O. Box 1059
Troy, MI 48099-1059
Phone: 248.637.4272
Fax: 248.649.1641