REPORT OF INJURY
STATEMENT OF UNDERSTANDING

Employee's Full Name: _____

Injury Date: _____ Social Security Number _____

Location of Incident: _____

I am claiming to have sustained an injury involving my

_____

I (__am), (__ am not) claiming that my current medical condition is work-related.

If Work-Related:
Employee will need to follow the City's reporting instructions. Failure to follow the instructions could delay Workers' Compensation payment(s) and could result in inaccurate information and reporting. The City has designated medical providers listed on the following page. **Prior authorization for medical treatment is required.** If an employee chooses to see a physician without prior authorization that is not the City's designated physician, Workers' Compensation will only pay for the first $500. Any amount over the first $500 will be the responsibility of the employee. This is not an admission of further coverage or claims responsibility.

____ I have received a copy of the Injury Reporting Procedures.

____ I have declined any type of medical treatment at this time.

If medical treatment is needed for this incident at a later date, the city's Injury Reporting Guidelines will need to be followed before obtaining medical treatment.

Employee Signature: _____ Date: _____

Authorized by: _____ Date: _____
Name/Title (Supervisor/Manager)

Employees may be required to submit to drug/alcohol screening after the involvement in a workplace or vehicular accident.

This is not an admission of further coverage or claims responsibility.

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