SELF INSURER ACCIDENT REPORT (SIF-2)

Worker Start Here

UBI | Risk class | CLAIM NUMBER

Business name of self insured employer

Employer's address

City State ZIP

Name of injured employee (First-middle-last)

Mailing address

City State ZIP

Employee's home phone ( )

Employer's phone # ( )

Social Security number

Dependent Children include unborn, estimate birthdate.
Benefits will be based, in part, on number of legally dependent children. Please indicate custody status of each child.

Name	Relationship	Legal custody (select one)	Date of birth
		Yes No	/ /
		Yes No	/ /
		Yes No	/ /
		Yes No	/ /

Marital status (select one): Married, Widowed, Separated, Single

Sex M F

Date of birth / /

Height

Weight

Job title when injured

Date of hire / /

Shift hrs

When did you last work? / /

Date of injury/exposure / /

Time of injury (Select one) AM PM

When did you return to work? / /

Name of children's legal guardian, if other than self. Phone # ( )

Address

City State ZIP

Part of body injured or exposed

Right Left

Where did the injury or exposure occur? Employer premises, Jobsite, Parking Lot, Other

Were you doing your regular job? Yes No

Was this incident caused by failure of a machine or product OR someone who is not a co-worker? (Select one) Yes No Possibly

Describe in detail how your injury or exposure occurred:
(Include tools, machinery, chemicals or fumes that may have been involved)

Did you report the incident to your employer? Yes No

Name/title of person reported to:

Date reported / /

If reporting of incident was delayed, why?

Business name and address where injury or exposure occurred

Address

County

City State ZIP code

List any witnesses

Was your employer contributing to your and/or your family's medical, dental and/or vision insurance on the date you were injured? Yes No

Do you consistently work overtime? Yes No

Do you have more than one rate of pay? Yes No

Do you have more than Yes No

Have you ever been treated for same or similar condition before? Yes No If so, When?

Rate of pay at this job (Write amount, select one) $ Hour Week Day Month

Hours/day

Days/week

Additional earnings (daily average) (Write amount, select one) $ Tips Piecework Commission

Did you receive a bonus within the last 12 months? Yes No $

Name of attending physician

Address

City State ZIP

Medical Release authorization: I hereby authorize my physician, hospital, agency or organization to disclose to my employer or their representative or the Dept. of Labor & Industries any medical records or other information regarding treatment which has previously been furnished to me.

Today's date / /

Worker's signature X

I have read the legal notice on the reverse side of employee's copy. I declare that these statements are true to the best of my knowledge and belief.

Today's date / /

Worker's signature X

Employer Start here

Date returned to work / /

Was employee engaged in the regular course of employment when injured? (select one) Yes No

Do you agree with employee's description of the accident? If not, explain.

Hourly rates of pay
$ /hr hrs/dy days/wk
$ /hr hrs/dy days/wk

Monthly Salary $

Other, explain:

Average hrs including O/T worked Hrs: Day Mo

If seasonal part time or intermittent, provide 12 months gross wages $

Average daily earnings from piecework, tips and commissions as reported to IRS

Will you pay this employee full salary or wages during period of disability? (select one) Yes No

Average monthly value of all bonuses paid 12 months prior to injury $

L & I use only

Fatality Yes No

Date reported to employer / /

3rd party involved? Yes No

Were you contributing to this worker's and/or family's medical, dental and/or vision insurance on date of injury? Yes No

If so, how much did you pay? Per Mo.

Was this medical insurance in effect on the day of injury? Yes No

When will coverage end? / /

Worker's copy mailed Yes No

Treatment only Yes No date closure mailed / /

Treatment only ROR: Lt. duty provided Yes No Associated costs $

I declare that the foregoing statements are true to the best of my knowledge and belief.

Date / /

Signature