



**WORKERS' COMPENSATION CHECKLIST**

**Employee Name:** \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_

**First Report of Injury**

**Panel of Physicians – signed by employee**

**HIPAA Release – signed by employee**

**Employee Accident Report**

**Supervisor's Accident Investigation Report**

**Accident Witness Report**

**Preparer's Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

*Please submit with First Report of Injury Form within 24 hours*