Professional EMPLOYER SERVICES

Please call us immediately following a work related injury/illness with as much of the following information as possible. Call 1-800-775-2404 or FAX to 1-866-214-9505

NOTICE OF INJURY

EMPLOYER INFORMATION

Date: _____ / _____ /_____

Employer Name: _____

Contact Person: _____

Address/Location: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ -_____

INJURY INFORMATION

Employee Name: _____ Home/Cell Phone: (_____) _____ -_____

Injury Date: _____ / _____ /_____ Date Employer Notified: _____ / _____ /_____

Time Shift Began: _____ Time of Injury: _____

Where did the injury occur: _____

What was the employee doing leading up to the injury: _____

How did the injury occur: _____

Body part(s) affected: _____

Type of injury: _____

Returned to work: Yes ☐ Date Returned: ____ / ____ /____ No ☐

PHYSICIAN INFORMATION

Physician/Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ -_____

Treated in the Emergency Room: Yes ☐ No ☐ Hospitalized overnight: Yes ☐ No ☐

1301 South Vista Avenue, Suite 207 • Boise, Idaho 83705 • (800) 775-2404 • Fax (866) 214-9505
Email • workcomp@employersresource.com