



# CIRMA Injury Reporting Information

Report Claims at NetClaim.net or 1-800-OK-CIRMA

**Keep this Form for your own Records—Do Not Submit to CIRMA**

## Event Date/Time

Incident Date and Time: \_\_\_\_\_ Employer Notified: \_\_\_\_\_

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## Reporter & Location Information

Reported by: \_\_\_\_\_ Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Location Code: \_\_\_\_\_ Location Name: \_\_\_\_\_ Address: \_\_\_\_\_

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## Claimant Information

Social Security Number of Claimant: \_\_\_\_\_

Claimant Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: Male Female

## Employment

Job Title: \_\_\_\_\_ Status: \_\_\_\_\_

Claimant's Supervisor: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

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## Incident

Description of the Injury: \_\_\_\_\_  
\_\_\_\_\_

Cause: \_\_\_\_\_ Body Part: \_\_\_\_\_

Nature Code: \_\_\_\_\_

Medical Provider (if known): \_\_\_\_\_ Address of Medical Provider: \_\_\_\_\_

Name of Doctor (if known): \_\_\_\_\_

Witness Name (if any): \_\_\_\_\_

Lost time from work (if known): \_\_\_\_\_ Return to work date: \_\_\_\_\_

Loss Location Entity: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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## Additional Information

Job Classification code: \_\_\_\_\_

Time the employee began work on the day of injury: \_\_\_\_\_

Supervisor Notice Date: \_\_\_\_\_ Claim Incident Number:

This is assigned by NetClaim.net (at the FINISH tab) or by the Hotline operator.