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YORK
Risk Services Group

PO Box 620, Howell MI 48844-0620

Report of an Injury to an Employee

COMPLETE AT ONCE

Phone: 800-533-9366 Fax: 800-688-9892

Has this employee been disabled for more than 7 days? **Yes** ☐ **No** ☐

If the injured employee returns to work on or before the seventh day, no further report is required.
If he/she is **disabled seven days or more,** please send corrected report of injury immediately.

Client Name or Individual Self-Insured Account Name	**Policy No.**
Location/Department No.	WC Job Class NCCI Code

Employer Name		Fed ID#		
Office Address	City	State	Zip	Phone (include area code)
Location of Injury if Different	City	State	Zip	Type of Business

Employee Name (First, Middle, Last)		Phone No. (w/area code)		Social Security No.
Date of Birth	Male ☐ Female ☐	Hire Date		Termination Date
Address	City	State	Zip	
Employee's Occupation	Hourly Rate			Employee's Supervisor

Injury or Industrial Illness			
Date of Injury	Time	a.m. ☐ p.m. ☐	Last Day of Work
Date Employee First Saw Doctor	Was the Injury Fatal? Date of Death:		Date of Return To Work
Location of Injury (area of facility/department)			Was the place of the accident or exposure on the employer's premises? Yes ☐ No ☐
Nature of Illness or Injury (include what body parts affected)			
Describe How Illness or Injury Occurred			
Any Witnesses			
Doctor's Name and Address of Hospital			
If Hospitalized, Name and Address of Hospital			

Date of Report	Made Out By	Title	Phone

Please include a copy of the supervisor and/or employee report of the accident, if available.

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