QUALCARE INC

888-342-3839

# QUALCARE, INC. FIRST ACCIDENT REPORT

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|---|---|---|
| Taken by: _____Report Date to QC _____To Employer_____ Report Time:_____Caller : _____ | | |
| Social Security # (*If available)*: | Injured EE Name: (check spelling)<br>Last: First: | |
| Home Address: | | |
| DOB: | Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed | Sex: ☐ M ☐ F |
| Person Injury Reported To: | Date of Injury: Time: | |
| Employer/Municipality/School Board: | Location/Department: | |
| Occupation: | | |
| Employment Status: ☐ Full-time ☐ Part-Time ☐ Seasonal ☐ Volunteer; Work Hours:_____ | | |
| Witness (name & number) | | |
| Where accident occurred: | Did accident occur on premises? ☐ Yes ☐ No | |
| City: State: Zip | | |
| Nature of Injury: (strain, contusion, laceration, etc.) | | |
| Injured Body Part: | Dominant Hand? ☐ Right ☐ Left | |
| Accident Description: (Cause of Injury) | | |
| Has employee received medical attention? _____ Yes _____No<br>If "yes", where? | | |
| Where is employee now? | | |
| Best way to reach employee:<br>Home Phone: Cell Phone: Work Phone: ext: | | |
| Was Safety Equipment Provided? ☐ Yes ☐ No | Were Safety Devices Used? ☐ Yes ☐ No | |
| Is employee out of work? ☐ Yes ☐ No | Last date employee worked? | |
| | Date of Hire: | |
| Salary/Wages: $_____ Number of days worked in week?_____ | Shift: ☐ Days ☐ Evenings ☐ Nights | |
| Does employee have another employer or attend school? If yes, name of employer or school: | | |
| Previous Medical Condition? | | |
| Current Medications? | | |
| Previous workers' compensation injury? | Year and body part: | |
| Primary Care Physician name and phone #: | | |
| Advised to call back for pharmacy ☐ Yes ☐ No; | Advised to call NCM: ☐ Yes ☐ No | |
| Initial Treatment PROVIDER/FACILITY: NAME/ADDRESS/PHONE: | | |
| Initial Treatment Directed by: | Case Assigned to: | |