



# EMPLOYEE'S REPORT OF INJURY ON THE JOB

(To be filled out by employee only)

Employee Name (Please Print): \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ AM  PM

What job were you doing when you were injured?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was anyone with you when you were injured? List their name(s) here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly describe how you were injured:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What parts of your body were injured?

\_\_\_\_\_  
\_\_\_\_\_

Was medical treatment away from the job site offered? Yes  No

If treatment was offered, but declined, **please sign:** \_\_\_\_\_

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.

\_\_\_\_\_  
Employee Signature

Date

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Witness Signature

Date

**SEND ORIGINAL TO:**

Consolidated Benefits Resources, L.L.C.  
P.O. Box 581630  
Tulsa, OK 74158-1630  
(918) 594-5170  
(800) 826-0419 (toll free)  
(918) 594-5171 (fax)  
(888) 594-5171 (toll free fax)

**RETAIN COPY FOR YOUR FILE**

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.