



EMPLOYEE'S REPORT OF INJURY ON THE JOB

(To be filled out by Employee only)

Employee Name (Please Print):

Nombre del empleado (Letra de imprenta): _____

Date of Injury:

(Fecha del Accidente:) _____

Time:

(Hora:) _____

AM

PM

AM

PM

What job were you doing when you were injured?

(¿Qué tipo de trabajo estaba usted desempeñando cuando se lesionó?) _____

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

(¿Estaba alguien más con Usted cuando se lesionó? Liste su(s) nombre (s) aquí: _____

Briefly describe how you were injured: (Describa brevemente cómo se lesionó:)

What part(s) of your body were injured? (¿Qué parte (s) de su cuerpo se lastimó?)

Was medical treatment away from the job site offered?

(¿Le proporcionaron atención médica en algún sitio fuera del trabajo?)

Yes
Sí

No
No

If treatment was offered, but declined, please sign:

(Si le ofrecieron atención médica pero usted la rechazó, por favor firme:) _____

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.

(Yo declaro bajo pena de perjurio que he examinado todas declaraciones contenidas aquí, y que a mi mejor saber y entender, todas son correctas y completas.)

Employee Signature (Firma del empleado)

Date (fecha)

Employer (Empleador)

Witness Signature (Firma del Testigo)

Date (fecha)

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.

(Cualquier persona que cometa fraude a la compensación de trabajadores, será convicto y culpable de un grave delito)