MISSISSIPPI WORKERS' COMPENSATION COMMISSION

P. O. Box 5300
JACKSON, MISSISSIPPI 39216

EARLY NOTIFICATION OF SEVERE INJURY

Date of Injury _____

Employee's
Name _____

Address _____ Home Telephone # _____

Employer _____

Address _____

Carrier _____

Name and Address of Hospital _____

_____

Name and Address of Physician _____

_____

Type of Injury: ☐ Major Amputation ☐ Spinal Cord Injury ☐ Brain Damage

☐ Loss of Sight, one or both eyes ☐ Severe Burns, 2nd° and 3rd°

☐ Other: explain _____

_____

Remarks: _____

_____

_____

Signed _____

Title _____

NOTICE: This notification must be filed with MWCC immediately.
THIS DOES NOT REPLACE B-3
Send this report direct to:

Mississippi Workers' Compensation Commission
P.O. Box 5300
Jackson, MS 39216

Attention: Rehabilitation Unit

MWCC Form R-1 (Adopted 7-82)