

**\*\*\*EMPLOYEE INFORMATION\*\*\***

Employee Name (First & Last)		Gender	Hired Date	Hired in NH	
ID Type - Employee ID	Date of Birth	Age	Occupation when Injured		
Employee Address	Telephone	Wages per Hour	Hrs per Day	Days per Week	Average Weekly Earnings

**\*\*\*INJURY INFORMATION\*\*\***

Injury Date / Time	Date Employer Notified of Injury	Location/Jobsite & Business Name where accident occurred			
Disability Began Date					
Claim Type	Full Wages Paid on Injury Date				
Accident Description					
Body part Injured		Cause of Injury			
Nature of Injury		Witness Name	Witness Phone		
Returned to work?	If so, what date?	If so, at what occupation?	If so, at what duty status?		
Initial Treatment			Initial Treatment Date		
Name of Treating Physician		Name of Treating Hospital		Has injured died? If so, what date	

**\*\*\*EMPLOYER INFORMATION\*\*\***

Employer Name		Employer FEIN	Industry Code
Employer Contact Name	Contact Phone Number	Employer Business Address	
Managed Care Organization			
Leased Employee? Client Company		OCIP/Wrap-Up Policy? Name of policy holder	

**\*\*\*INSURER INFORMATION\*\*\***

Insurance Carrier	Insurer Type	Policy Number	Telephone Number

**\*\*\*SUBMITTER INFORMATION\*\*\***

Submitter Name	Title of Submitter	Represents	Telephone Number