

**ARIZONA WESTERN COLLEGE
WORK-RELATED NOTICE OF INJURY**



Insurance Carrier Information

CopperPoint Western Insurance Company
Policy Number: 1003230
PO Box 33069
Phoenix, AZ 85067

Most injuries can be treated at an Urgent Care. The hospital emergency room should be used only for serious injuries that require specialized care or services.

Section 1 – Employee Information

Name _____
Job Title: _____
Department: _____
Supervisor: _____
Work Phone: _____

Section 2 – Incident Details

Date of Incident _____
Time of Incident: _____
Location of Incident: _____
Date Reported: _____
Reported to (name/title): _____

Section 3 – Work Schedule

Number of Days Per Week Usually Worked: _____
Hours Per Day Worked: _____
Time Working Hours Begin: _____
Time Working Hours End: _____
Last Day of Work After Injury: _____
Date Returned to Work: _____

Section 4 – Description of Incident

Describe in detail what happened, including what you were doing just before the incident and how the injury occurred:

Section 5 – Injury Details

Type of Injury (e.g., cut, burn, sprain): _____
Body Part(s) Injured: _____
Was medical treatment provided? Yes / No If yes, by whom: _____
Were you transported to a medical facility? Yes / No If yes, which facility: _____

Section 6 – Witness Information Name(s) of Witness(es): _____

Contact Information: _____

Section 7 – Cause and Prevention

In your opinion, what caused the injury/accident? _____
What could be done to prevent this type of incident in the future? _____

Section 8 – Employee Signature

I declare that the information provided above is true and accurate to the best of my knowledge.

Employee Signature: _____ **Date:** _____

HR/Workers' Compensation Use Only

Date Received in HR: _____
Claim Filed With Carrier? Yes / No Carrier Name: _____
Claim Number: _____