MAISL WORKERS' COMPENSATION FUND

EMPLOYER'S REPORT OF INJURY

SHORT FORM

*** * THIS REPORT MUST BE COMPLETED AND SIGNED BY THE EMPLOYER * ***

EMPLOYEE

Full Name (First, Middle Initial, Last)	Soc Sec No.	☐ Male ☐ Female

Street	City	State	Zip

Employee Telephone ( )	Date of Birth	Marital Status	Dependents

Occupation	Employee Department	Date of Hire

INJURY

Date of Injury	Time of Injury ☐ AM ☐ PM	Time employee began work ☐ AM ☐ PM	City + ZIP CODE Where Injury Occurred

What kind of injury? (contusion, cut, fracture, sprain, strain, etc.)	Body Part Injured

How did injury occur?

What was employee doing just before incident occurred?

			Did Employee Die ☐ Yes ☐ No
Last Day Worked	☐ No Time Lost	Date Returned to Work	If yes, what date?

MEDICAL

Was employee treated in an Emergency Room? ☐ Yes ☐ No	Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No	Case No. from Hospital Log

Physician/Clinic

Address

Telephone ( )

Hospital

EMPLOYER

Full Business Name	Federal ID# (Required by BWC)

Mailing Address

Location

Address of Accident Location (if different from mailing address)

Contact	Telephone ( )	Date Injury Was Reported to Employer

Please return to the Michigan Municipal League

PO Box 5174
Southfield, MI 48086-5174
(800) 482-0626

3501 Lake Eastbrook, S.E., Suite 150
Grand Rapids, MI 49546
(800) 752-7477

Preparer's Signature (Employer) _____ Date _____

Preparer's Name (Please Print) _____ Preparer's Title (Please Print) _____

5614MML Aug.02