Injury Reporting Information

Send the saved completed form to hrdept@rockyhillct.gov or confidential fax to 860-257-1109 immediately following the incident. Send supplemental documents as soon as possible to the same email or fax.

Save completed form for your Confidential Records.

Electronically by using SAVE AS or Physically by PRINTING.

Event Date/Time

Incident Date and Time: _____ **Employer Notified Date and Time:** _____

Location of Incident: _____

Reporter Information

Reported by: _____ **Title:** _____ **Phone Number:** _____

Claimant Information

Claimant Name: _____

Home Phone: _____ **Work Phone:** _____

Home Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Marital Status:** Select One... **Gender:** ☐ Male ☐ Female

Employment

Job Title: _____ **Department:** _____ **Status:** Select One...

Claimant's Supervisor: _____ **Title:** _____ **Phone:** _____

Incident

Cause of Injury: Select Cause of Injury **Body Part:** Select Body Part...

Nature of Injury Code: Select Injury Code...

Witness(s) Name (if any): _____

Did they decline medical attention? ☐ **Yes** ☐ **No**

If they went to their own medical provider:

Medical Provider (if known): _____ **Address of Medical Provider:** _____

Name of Doctor (if known): _____

Emergency Contact Person: _____

Additional Information

Job Classification code: Select One...

Time the employee began work on the day of injury: _____

Return to Work Date: _____

Supervisor Notice Date: _____ **Claim Incident Number:** [ ]

This is assigned by NetClaim.net (at the FINISH tab) or by the Hotline operator.

Please describe incident: